Canadian Hospital

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AUGUST, 1952

Official Journal—Canadian Hospital Council

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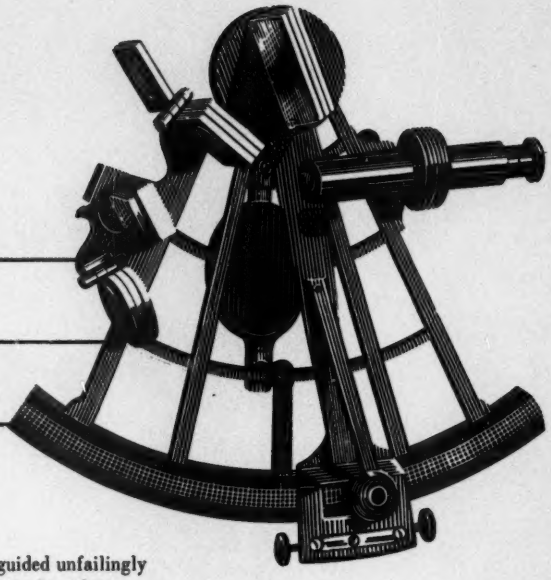

For countless centuries, ships at sea have been guided unfailingly by the stars. So dependable are these time-tested, nautical guides, that even today, with the aid of modern instruments, navigators still set their course by "shooting the stars."

For many years, The Canadian Laundry Machinery Co. has guided hospitals in their choice of laundry equipment. During this time we have gained a thorough knowledge of hospital laundering problems and how to solve them most economically and efficiently. This experience is your guarantee that every CANADIAN machine is built for years of dependable and superior performance. Our complete planning, advisory and technical service is your assurance that CANADIAN can be relied upon to help you select equipment which best suits your needs.

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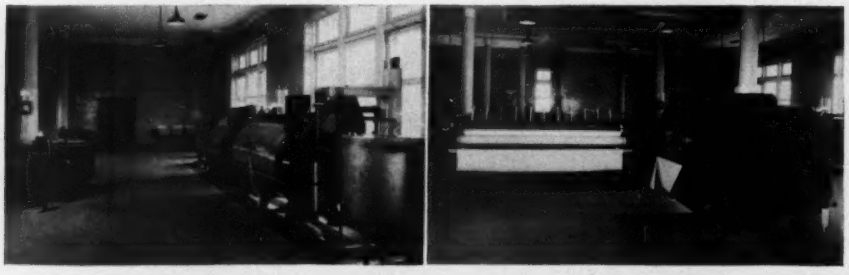

At Mont Providence School for Mentally Retarded Children, Montreal North, Que., the new laundry department was planned and completely equipped by CANADIAN. Shown at left are Open Top Extractor, Solid Curb Extractor and three CASCADE Washers. At right are 6-Roll STREAMLINE Ironer and ROTAIRE Conditioning Tumbler.

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these are Picker's military assignments:

Portable X-Ray Generator and Control Units

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(all in spring-suspended, shock-absorbing chests)

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Contents

Vol 29 **August, 1952** No. 8

(For Subscription Rates see page 74)

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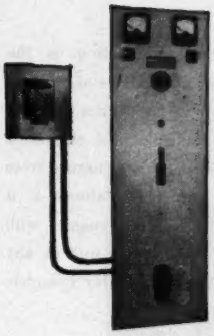

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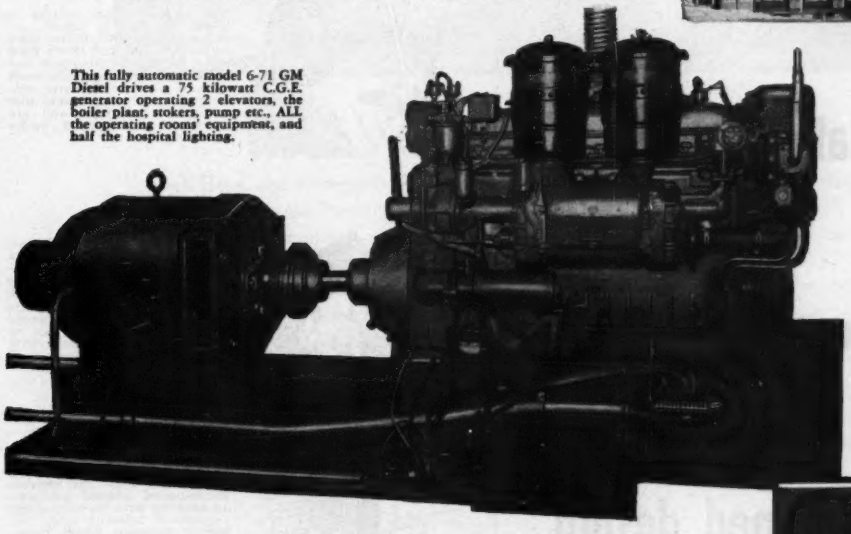
This fully automatic model 6-71 GM Diesel drives a 75 kilowatt C.G.E. generator operating 2 elevators, the boiler plant, stokers, pump etc., ALL the operating rooms' equipment, and half the hospital lighting.



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HIS Edwards Fire Alarm station is the result of a careful survey and analysis of requirements among fire protection authorities, government experts, architects and electrical engineers. Its design is entirely different in appearance from the old-fashioned bulky cast iron stations. It is available in standard lustrous red enamel with highly-polished bright metal trim as well as any desired color or finish. Write now for complete details and specifications.

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The new Edwards station is quick and easy to install . . . cuts man-hour installation costs up to 30% . . . and that's good news for both contractors and architects. Unlike old-fashioned stations all new Edwards stations have terminal blocks that are front connected and are therefore readily and easily accessible.

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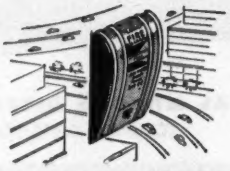

It's a smooth, gracefully contoured die-casting that literally "hugs" any wall. The lustrous twice-baked enamel surface—in keeping with modern architecture—is relieved with four highly polished metal bands. It's the smallest code station available today with a maximum projection of only 1⅝" from the wall.

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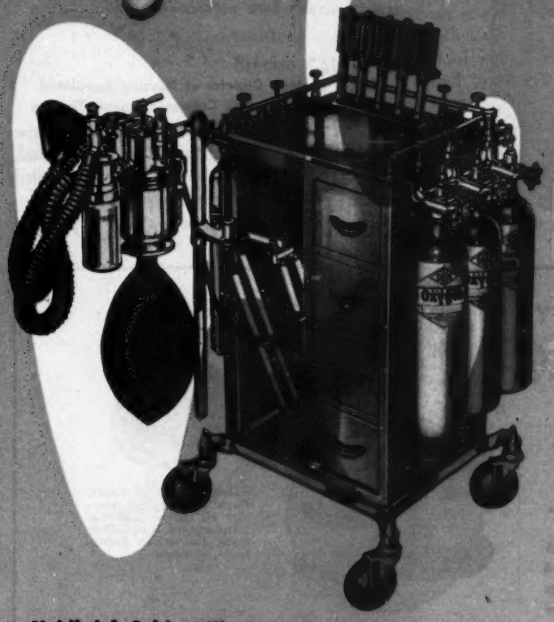

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◂ Notes About People ▸

Devotes Full Time to Le Comité des Hôpitaux du Québec

Rev. H. L. Bertrand

The resignation of Rev. Father Hector L. Bertrand from the presidency of the Catholic Hospital Council of Canada, in order that he may devote his full time to the work of Le Comité des Hôpitaux du Québec, calls for special mention. In a short period of five years, Father Bertrand has become nationally known for his fine work, his engaging personality, and his vigorous enthusiasm and interest in better hospital service. We may expect great things from Quebec under his undivided leadership. He is succeeded as president of the Catholic Hospital Council by Rev. Father John Fullerton of Toronto, with Rev. Father Henri Légaré, O.M.I., of Ottawa, as executive director—*L.O.B.*

Traduction

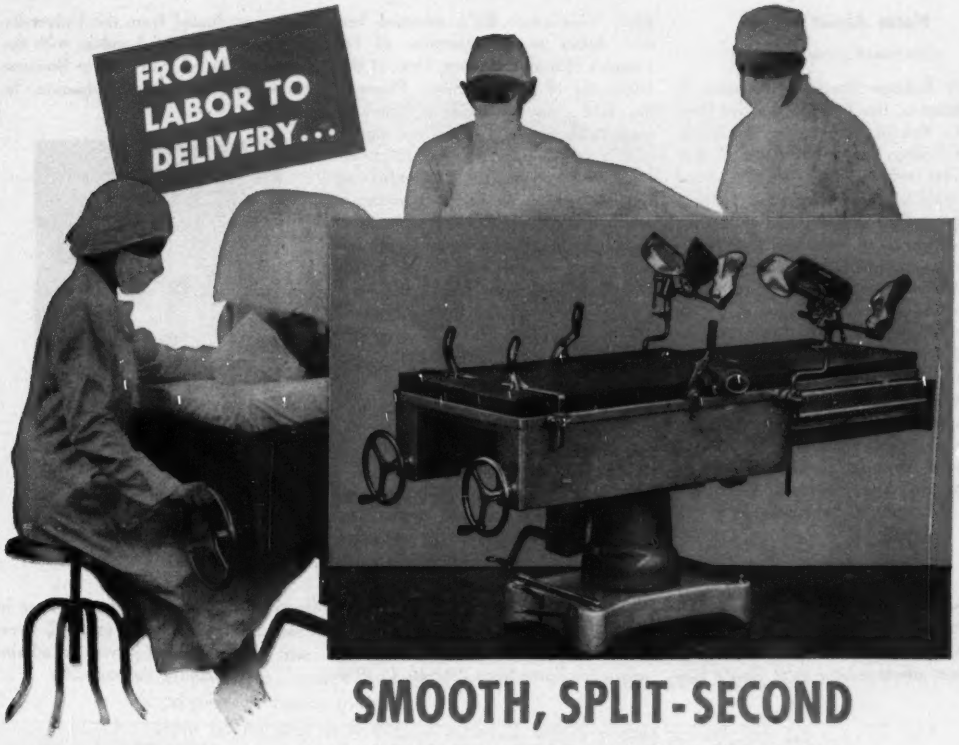
Il nous faut faire mention toute spéciale de la démission du Révérend Père Hector L. Bertrand qui quitte la présidence du Conseil des Hôpitaux Catholiques du Canada afin de se dévouer entièrement au travail du Comité des Hôpitaux du Québec. Au cours de cinq courtes années, le Père Bertrand s'est fait une réputation nationale, grâce à son excellent travail, à sa personalité engageante, au grand enthousiasme et à l'intérêt qu'il a apportés au perfectionnement des services d'hôpitaux. Sous sa direction sans partage, on pourra s'attendre à de grandes choses du Québec. Le Père Bertrand est succédé à la présidence du Conseil des Hôpitaux Catholiques du Canada par le Révérend Père John Fullerton de Toronto, avec le Révérend Père Henri Légaré, O.M.I., d'Ottawa, comme directeur éxécutif.

* * *

New Director of Nursing Appointed at Women's College Hospital, Toronto

Miss Jessie Young, director of nursing at the Kitchener-Waterloo Hospital, Kitchener, Ont., has been appointed the new director of nursing at Wo-

(Continued on page 16)



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Notes About People

(Continued from page 12)

men's College Hospital, Toronto. A graduate of the Toronto General Hospital's School of Nursing, in 1933, Miss Young was on the staff of that hospital from 1934 to 1940. She joined the staff of the Port Arthur General Hospital, Port Arthur, Ont., as instructor of nurses in 1940 and became assistant superintendent of the hospital in 1942, a post she held for three years. Later, Miss Young enrolled at Teachers' College, Columbia University, New York City, where she received a Bachelor of Science degree in teaching and supervising in schools of nursing. On completion of her course, she became educational director at the Hamilton General Hospital, Hamilton, Ont. In 1948, Miss Young was appointed director of nursing at the Kitchener Waterloo Hospital.

* * * *

Sr. Florence Mary Administrator at St. Joseph's Hospital, Kenora, Ont.

Sister Florence Mary, formerly assistant administrator at St. Paul's Hospital, Vancouver, B.C., assumed her new duties as administrator of St. Joseph's Hospital, Kenora, Ont., at the beginning of August. Sister Florence has held many positions in the hospital field. She is a registered nurse, with post-graduate training in obstetrics, received at the University of Seattle, Seattle, Wash. She was supervisor of the medical ward at St. Vincent's Hospital, Portland, Ore., and supervisor of obstetrics at St. Paul's Hospital, Vancouver. Sister Florence served as a councillor for the Catholic Conference of British Columbia for two years and as secretary, last year.

* * * *

Harold G. Dillon Joins Staff of Canadian Hospital Council

Harold G. Dillon has been appointed administrative assistant, Committee on Education, Canadian Hospital Council and senior research fellow, Department of Hospital Administration, School of Hygiene, University of Toronto. Born in Collingwood, Ontario, Mr. Dillon served with the Royal Canadian Air Force from 1941-46. In 1950, he was graduated from the University of Western Ontario, London, with the degree of Bachelor of Arts in Business Administration. After graduation, he

Harold G. Dillon

enrolled in the post-graduate course in hospital administration at the University of Toronto and served his admin-

(Concluded on page 20)

GOOD FOR THE PATIENT . . . .
BETTER FOR THE NURSE . . . .

BEST FOR THE HOSPITAL!

In many hospitals nurses and kitchen help never seem to catch up on work. Morale is low and overhead keeps going up like a fever. But when management prescribes a strong dose of Lily® paper service, symptoms disappear almost overnight!

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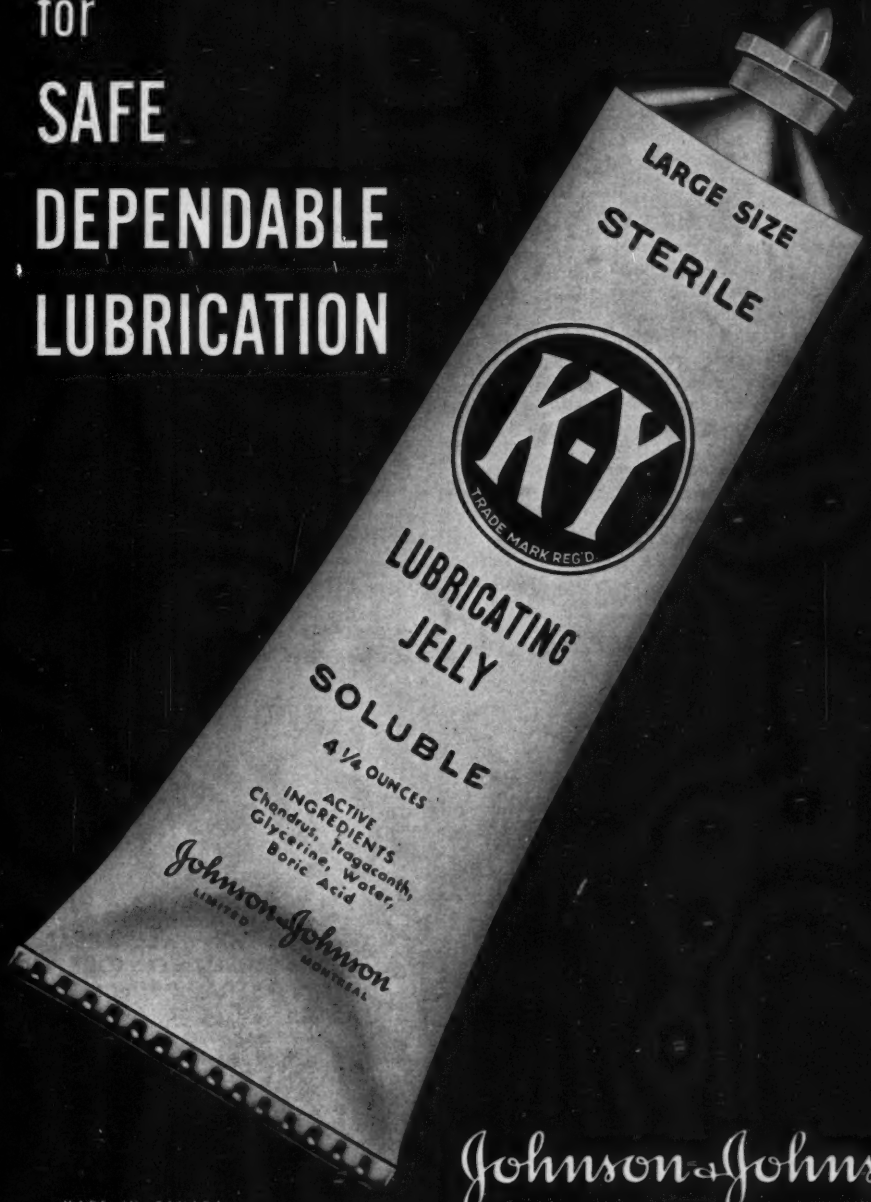

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Notes About People

(Concluded from page 16)

istrative residency at the Victoria Hospital, London, Ont.

* * * *

Sister M. Mona

The death of Sister M. Mona on May 31st, 1952 brought to a close the career of one of New Brunswick's most outstanding and esteemed nurses. Sister Mona graduated from St. Joseph's Hospital, Saint John, N.B., in 1918. Following graduation, she held many responsible positions in the hospital. Later, Sister Mona was stationed in Prince Albert, Sask., where she was superintendent of Holy Family Hospital. At the time of her death, she had charge of the out-patient department at St. Joseph's Hospital, Saint John.

Sister Mona's unswerving devotion to duty characterized her life. Her friendly and sympathetic nature, together with her unusual interest in all phases of hospital work, won for her innumerable friends. Sister Mona could discuss with equal fervor the tasks of the hospital administrator, the responsibilities of the surgical supervisor, or the latest development in technique in the clinical laboratory. In her dealings with the patients, Sister Mona reflected the kindness and charity of Christ.

The Community of the Sisters of Charity of the Immaculate Conception have lost a valuable member and the nursing profession a devoted and loyal friend.

* * * *

Dr. L. E. Ranta Joins Staff of Vancouver General Hospital

Dr. Lawrence E. Ranta has joined the staff of the Vancouver General Hospital, Vancouver, B.C., as Assistant Director (Medical). Dr. Ranta was formerly assistant to the Dean of the Faculty of Medicine, University of British Columbia, and associate professor of bacteriology and preventive medicine.

* * * *

New Administrator at Belleville, Ont.

Kenneth E. Box, formerly assistant administrator and comptroller of the Greater Niagara General Hospital, Niagara Falls, Ont., has been appointed administrator of the Belleville General Hospital, Belleville, Ont. Born in Toronto, Ont., Mr. Box completed his academic training in England, where he served with the British Army during World War II. In 1946, he joined the staff of the North Vancouver General Hospital, Vancouver, B.C.; later becoming assistant administrator of that hospital, prior to his appointment at the Greater Niagara General Hospital.

* * * *

Matron Appointed at Mt. Forest, Ont.

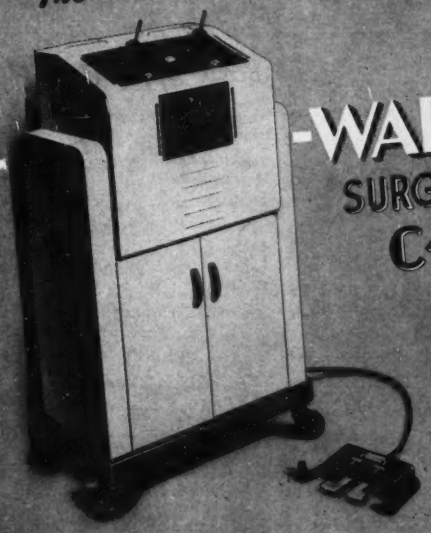
Mrs. J. Benny has taken over her new duties as matron at the Louise Marshall Hospital, Mt. Forest, Ont. Mrs. Benny, who began her nursing career in Kingston, Ont., was matron of the Groves Memorial Hospital, Fergus, Ont., for a time.

* * * *

Superintendent Appointed

Miss Baycroft, of Huntsville, Ont., has been appointed superintendent of the Bruce Peninsula District Memorial Hospital, Wiarton, Ont. Miss Baycroft, who has had considerable experience with the Red Cross Society, commenced her new duties in July.

For The Urologist—
The Utmost In Electrosurgical Utility!



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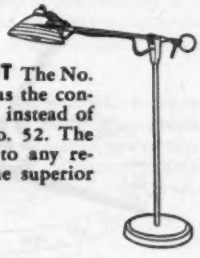
THE ANAESTHETIST BECAUSE: He gets proper, color-corrected light for quick *perception of cyanosis.* He also knows that the Castle Safelight is explosion-proof and approved by the Underwriters' Laboratory for use in Class 1, Group C, Hazardous Locations.



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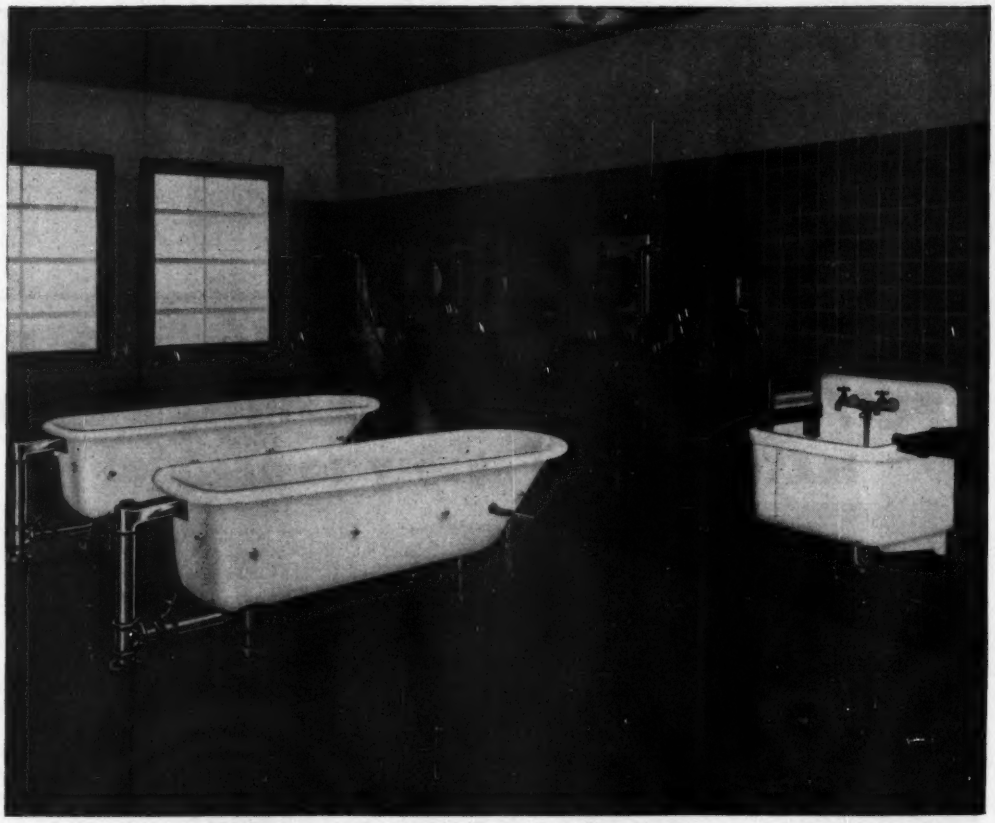

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L. O. Bradley, M.D., Editor

The CANADIAN HOSPITAL

Toronto, August, 1952 Vol. 29 No. 8

Obiter Dicta

Doctors Can Help to Curb Rising Costs of Medication

A RECENT letter from a hospital trustee asked pointedly: is the medical staff, is the doctor responsible for the rising cost of hospitalization? He then went on to elaborate on mounting expenditures for drugs and medications as one major factor in the increase that is under the direct control of the physician. Certainly, the medical profession and the doctors individually have a responsibility and a very clear one. It is to the individual patient and to the community as a whole.

The seemingly high cost of drugs and medicines is a frequent complaint from patients and by hospital management. Relatively and actually, the per diem charges to the patient have been moving up steadily. In total, the annual expenditure by the hospital for medications has been rising more rapidly than any other segment of the hospital bill.

On the other hand it must be remembered, reiterated, and re-emphasized that there is a greater armamentarium of effective drugs today than ever before. This has resulted in shorter hospital stay, more certain recovery and longer life. It means also a greater specificity of treatment now, that is the right drug for the right illness. In turn, a greater responsibility rests on the physician and the supporting hospital services to make early accurate diagnoses so that the appropriate treatments may be quickly applied. Nevertheless, it is still true that in many situations, expensive pharmaceuticals are prescribed without clear indication.

The hospital administration is not in a position to decide whether or not a certain drug should be given or for what period and dosage. Only the attending doctor can give these orders. The judgment as to when and where certain medications are given excessively or unnecessarily must rest with the medical staff. It is their responsibility in the course of medical audit to self-evaluate this aspect of medical practice in hospital. They must exert the necessary controls, if warranted, to see that unnecessary use of drugs and medications is kept to a reasonable minimum.

A greater measure of success in keeping these particular expenditures within reason can be attained if the medical staff is kept informed. The monthly cost of medications as well as other hospital costs should be presented at the medical staff meetings, in addition to the individual cases that are a financial burden to the hospital management. A special committee, which might include the pharmacist, may be very useful. We may expect the co-operation of medical staff if they are brought in on the problem.

Fire Prevention—a Constant Concern

SEVERAL of the provincial health survey reports, tabled during the past few months in the House of Commons, have drawn attention to obsolete hospital buildings, often fire hazards, which are in active use. Recent fires in small hospitals at Tofino, B.C. and Hanover, Ont. underline the seriousness of these findings.

Unfortunately, it is not economically possible to replace all obsolete facilities as many communities have heavy financial burdens from the construction and maintenance of other public utilities and services. Nor would it be feasible to close the doors of these unsafe units for, in some regions, they might account for 25 to 30 per cent of available hospital beds. As October 5-11 is National Fire Prevention Week, several suggestions are in order.

When new hospitals or additions are contemplated, construction and layout should be given most careful consideration as the primary step in preventing destruction by fire. Hospitals should invite inspection regularly by local or provincial fire authorities. There should be routine tours of the institution by the administrator, as well as the official who is responsible for the protection of lives and property from loss by fire. The prevention of fire should be made a concern of the entire staff, as 24-hour vigilance is a necessity. Fire is a year 'round problem. Adequate fire protection and fire fighting equipment should be supplied.

Of course, none of these suggestions can be as effective as fire-resistant hospital buildings but they will certainly be helpful until new facilities become available.

Dr. A. L. Swanson Appointed C.H.C. Executive Secretary

THE Board of Directors of the Canadian Hospital Council has announced the appointment of Dr. Arnold L. Swanson to succeed Dr. L. O. Bradley as executive secretary of the Council and editor of *The Canadian Hospital*. Dr. Swanson, who is Deputy Medical Superintendent of the Provincial Mental Hospital and Crease Clinic of Psychological Medicine at Essondale, B.C., will assume his new duties in Toronto as of September.

Born at Red Deer, Alberta, Dr. Swanson has resided in the province of British Columbia since childhood. After being graduated from U.B.C. in 1940, he attended McGill University medical school and interned at the Montreal General Hospital. On completion of his medical training he spent two years, 1944-1946, with the Royal Canadian Army Medical Corps. He then joined the medical staff of the British Columbia Mental Health Services and in 1948 was chosen to attend the course in hospital administration given at Northwestern University in Chicago. Having attained the degree of Master of Hospital Administration, Dr. Swanson spent the summer of 1949 inspecting hospitals for the American College of Surgeons. He then returned to the B.C. Mental Health Services and was shortly promoted to the position of Deputy Medical Superintendent at Essondale. He is a member of the Canadian Medical Association and a nominee of the American College of Hospital Administrators. He is married and has four children.

Dr. Swanson has consistently shown an active interest in community organizations. In 1943 he was president of the McGill Undergraduate Society; was later elected to the McGill Men's Honorary Society; and while in Chicago he became a member of the Hospital Club of Northwestern University. Dr. Malcolm T. MacEachern writes of him: "Dr. Swanson showed fine qualities when taking the course in hospital administration with us. He is a serious, thorough, competent, and diligent worker. Anything he undertakes he does well."

Traduction

Le Conseil d'administration du Conseil des Hôpitaux du Canada vient d'annoncer la nomination du Docteur Arnold L. Swanson comme successeur au Docteur L. O. Bradley, à titre de Secrétaire exécutif du Conseil et d'éditeur du journal *The Canadian Hospital*. Le Dr. Swanson est présentement le Député-surintendant médical de l'Hôpital provincial mental et de la Clinique de Médecine Psychologique a Essondale, Colombie-Anglaise. Il rentrera en charge à Toronto au début de septembre.

A. L. Swanson, M.D.

Né en Alberta, à Red Deer, le Dr. Swanson demeure en Colombie-Anglaise depuis son enfance. En 1940, il graduait à l'université de cette province, puis passait à l'Ecole de Médecine de L'Université McGill et complétait son internat à l'Hôpital Général de Montréal. Gradué médecin, il passa ensuite deux ans (1944-1946) dans le Corps Médical de l'Armée canadienne. Il s'attache ensuite aux services pour la santé mentale en Colombie-Anglaise, puis, en 1948, fut choisi pour prendre les cours en Administration pour les Hôpitaux à l'Université Northwestern de Chicago. Il y reçu sa Maîtrise en Administration des Hôpitaux. Pendant l'été de 1949, il fut inspecteur d'hôpitaux pour le Collège américain des Chirurgiens. It retourna ensuite aux Services pour la Santé mentale en Colombie-Anglaise, et fut rapidement promu au poste de Député-surintendant à Essondale. Il est membre de l'Association médicale canadienne et un nominataire du Collège américain des Administrateurs d'hôpitaux. Il est marié et le père de quatre enfants.

Le Dr. Swanson a toujours porté un intérêt actif aux organizations communautaires. En 1943 il était président de la Société des Sous-gradués à McGill; plus tard il fut élu à la Société "Men's Honorary" de cette même université; à Chicago il devint membre du Club-Hôpital de l'Université Northwestern. Le Dr. Malcolm T. MacEachern dit de lui: "Le Dr. Swanson a déployé de superbes qualités alors qu'il prenait le cours d'Administration avec nous. Il est un travailleur sérieux, achevé, compétent et appliqué. Il fait bien tout ce qu'il entreprend."

Protect your hospital against FIRE

Ray S. Clark,
Assistant Director,
Royal Victoria Hospital,
Montreal, P.Q.

ALL who are charged with the responsibility of administering hospitals should be fully aware of the dangers of inadequate preparation for fire prevention and protection but the fact remains that in a number of cases where large fires have occurred there is ample evidence to indicate that there was less than a good standard of fire safety measures in effect.

Authoritative information indicates the 10 major causes of hospital fires are:

1. Cigarettes or matches	20.7%
2. Defective Heating Systems including chimneys	13.2
3. Defective Electrical Power consuming appliances	10.9
4. Electrical fixed services (Defective power lines)	8.1
5. Spontaneous Ignition	8.6
6. Mishandling of flammable liquids	7.5
7. Kitchen Fire Hazards	5.7
8. Mishandling of Combustible Anaesthetic Gases	5.2
9. Mishandling of Oxygen	4.6
10. Combustible material too close to heating equipment	3.4

Further examination reveals the origin of fires as:

Basements — 33.2 per cent. These fires occurred chiefly in service areas that housed storerooms, heating and power plant, laundry, elevator shafts, incinerator and employee quarters.

First Floor — 19.7 per cent. These occurred mainly in patient areas and recreation rooms.

Upper Floors — 34.5 per cent. These broke out in patient areas, heating and power units, elevator shafts, operating theatres, oxygen service, and quarters for nurses or other personnel.

Attics — 12.6 per cent. These started in heating or power units, elevator shafts, stairways, et cetera.

The record also indicates that:

55.3% of all fires occur between the hours of 6 a.m. and 5 p.m.
25.4% from 5 p.m. to midnight.
19.3% from midnight to 6 a.m.

While automatic detection systems contribute in no small way to the protection program, it is interesting to note that first notice of the fire was given in:

69.3% of the fires by employees or patients
13.7 by automatic sprinkler alarm system
5.7 by spontaneous explosions
4.7 by outsiders
3.8 through automatic detectors other than sprinklers
2.8 by watchmen.

Of the fatal injuries reported:

80 per cent — were suffocated or overcome by smoke or fire gases. Chief contributing factors were inadequate exit facilities, trapped by explosion, bedridden or other physical handicaps, fire fighting and attempted rescue.

14 per cent — died as result of burns. Contributing factors: trapped by explosion or rapid spread of fire; bedridden or physical handicaps; smoking in the presence of oxygen; mishandling of oxygen or flammable liquids.

4 per cent — by explosions caused through ignition of anaesthetic agents by static sparks, cautery, et cetera.

2 per cent — by falls while attempting to escape, falls from escapes or roofs, falling parts of buildings.

A brief analysis of the foregoing statistics provides the basic information necessary to establish a fire prevention program in any hospital.

1. The majority of fires occur in basements or upper floors that house power units, service units or personnel.

2. Experience reveals that smoking and power plant deficiencies are the largest sources of fires, followed by carelessness and mishandling of combustible materials.

3. Most of the fires will occur between the hours of 6 a.m. and 5 p.m. and somewhat less danger between the hours of 5 p.m. and midnight but the danger of outbreak of fire is almost equally divided between day and night.

4. While the staff and patients will discover most of the fires, certain less frequented areas are best protected by automatic detectors.

5. Fatalities are chiefly due to inadequate exits and planned evacuation, while explosions due to carelessness will contribute a fair percentage of casualties.

Basically, all fire prevention and protection should stem from a built-in system installed at the time of building the hospital or during a program of renovations.

New construction is adequately protected in most instances because of the architect's knowledge of fire hazards and also because of the fact that most construction now comes under the jurisdiction of building codes. For many existing hospitals there is only the administration and the board of management to assume responsibility for the discovery and correction of major fire hazards.

Building Exits Code

A few items from the Building Exits Code for hospitals are worthy of comment:

Masonry wall and wood joist construction, or wood frame building should not exceed one storey in height.

Patients should not be accommodated or treated above the first storey in any hospital building if the building is constructed wholly or mainly of wood, unless the whole building has a sprinkler system which is installed according to the regulations of the Canadian Underwriters' Association.

If floor areas exceed 5,000 square feet they shall be divided by fire walls or by fire partitions with at least two hours' fire-resistant rating so that the largest sub-division shall not exceed 5,000 square feet.

Non fire-resistant buildings with floor areas exceeding 3,000 square feet shall have hazardous areas separated from the remainder of the building by a standard cut-off or protection by an approved automatic sprinkler system.

No more than 150 feet of corridor

An address presented at the hospital conference section, sectional meeting of the American College of Surgeons, Quebec City, Quebec, Feb., 1952.

without barrier against lateral passage of smoke shall be permitted and the enforcing authority may order fire walls or smoke barriers, or both, to be built in new or existing buildings where he finds that they are necessary for the safety of the occupants. Each storey in which 35 or more patients are housed shall be divided into at least two compartments by smoke barriers.

Doors in smoke barriers shall be so installed that they may be normally kept in open position but will be provided with fusible holding links that may be released by heat or they may be released manually.

Every shaft for light or ventilation, stairway, elevator, dumb-waiter, chute, et cetera, shall be continuously housed in approved enclosure walls and all openings thereto shall be protected by approved fire doors. Where glass is used, wire glass in fixed or automatic closing fire windows shall be employed. Every laundry chute, dumb-waiter or elevator shaft in a hospital over two floors high should have sprinkler heads installed at the top of each shaft and supplied with water from the domestic water system. All fire doors, except those on elevators operated by a regular attendant, in shaft enclosures, shall be self-closing.

Suitable fire exits and escapes, approved by the Provincial Fire Marshal, shall be provided for every hospital.

Exits should be placed in such a manner as to ensure that every room or point in open wards, day rooms, dormitories or dining rooms would be not more than 100 feet along the line of travel from the nearest exit.

No less than two exits should be provided for every floor including the basement. Each furnace and boiler room shall be provided with a direct exit to the outside.

Doors to interior stairways, used as exits, shall not open immediately on a flight of stairs but on a landing arranged so that not less than 22 inches of clearance, between a newel post and door in any open position, will be maintained.

All exit facilities and fire escapes shall be of a type suitable for the removal of patients in case of fire and should be so lighted that they can be used with safety at night. Illumination for such exit facilities shall be on a separate circuit.

When possible there shall be sufficient stand-pipes and hose to permit effective fire-fighting in any part of the hospital. There shall also be sufficient chemical or other hand-operated fire extinguishers to afford ample protection in any section.

A masonry or concrete vault with floor and ceiling ventilation should be provided for the storage of all flammable anaesthetic agents, flammable or explosive drugs, chemicals and alcohol.

With the exception of life-saving activities, nothing should take precedence over getting the fire reported to the nearest fire department. In every hospital there should be an electric or manually operated fire alarm system. Such a system should be modulated so that it comes promptly to the attention of the staff but not necessarily to the patients. Many alarm systems depend entirely upon the telephone. This is a mistake as the fire may completely disrupt the telephone service. Any such system should be supplemented by an independent alarm system which may or may not be connected directly to the fire department.

There is much to be said for the installation of automatic detectors in the less frequented areas, particularly the storage or service areas. While the initial cost may seem expensive, it only requires one serious loss through fire to compare the cost of installation and prevention with that of the loss incurred.

Assisting members of the fire department to the scene of the fire is as important as alerting them. Serious delays have occurred because no one was delegated to guide the fire fighters to the actual scene of the fire, both on the grounds and within the building. The firemen answering a call for assistance are not always familiar with the layout of the buildings and will need guidance. Insist that local firemen visit your hospital frequently to familiarize themselves with the plant. At the same time they can inspect for fire hazards. The value of such a program is obvious and I am sure your local fire department will be quite ready to co-operate.

Training Hospital Personnel

When provision has been made for proper reporting of fires, the next step must be the training of hospital personnel in the proper use of fire-fighting equipment. Every employee must be trained to recognize the importance of fire prevention and, in the event of a fire, the need for insuring its prompt control in order to safeguard the lives of all concerned. Such a program must be realistic and repeated frequently due to the constant change in personnel. It is not enough to have each person know how to use the extinguishers, they must also know where to find them in each area.

When conducting training courses in the use of extinguishers, never hesitate to use the actual extinguisher in order that the staff may become completely competent in the handling and use of such equipment. Refills for the common soda and acid or pyrene extinguishers are inexpensive when compared with the cost of fire losses. It is surprising to learn how many persons have no idea what to expect when using a fire extinguisher.

If every worker understands the method of operating extinguishers, knows how to sound an alarm, and is familiar with the procedure in case a fire occurs, the possibility of serious consequences is minimized.

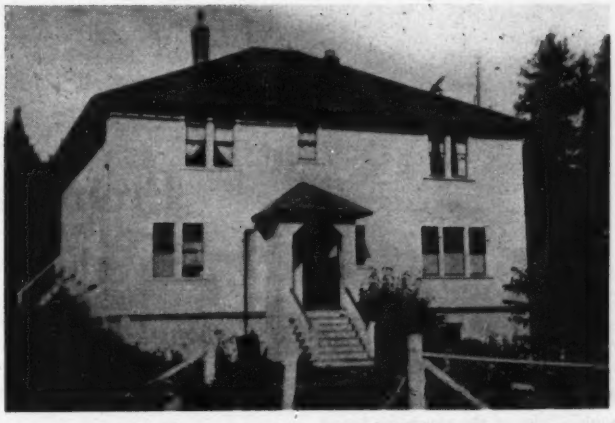
Fire-fighting equipment should never be considered more than a first aid measure limited to action of a very few minutes' duration or until more equipment can be brought to the scene. Great importance should be placed on first reporting the fire, then using the equipment. Many charred remains are mute evidence of someone's good intentions of trying to put out the fire alone and leaving the reporting until it was too late. Every minute counts.

Many will argue that it is not always necessary to enlist the aid of the fire department each time a small fire occurs. Quite often such a practice has a tendency to cause undue panic and distress. To be absolutely safe, it may be better to observe proven safety rules and advise the fire department each and every time. If necessary, arrangements can be made with the local fire department to reduce the noise and confusion to a minimum. We must never lose sight of the fact that the one fire we did not report could be the serious one.

The responsibility of fire control officer is assigned to the engineer on duty. During the day, he will of course be supported by certain administrative or departmental heads and at night by the night supervisor of nursing. Anyone who has experienced a fire will appreciate the need for a

Fire at Tofino, B.C.

Early in May, fire swept through the Tofino General Hospital, and, in less than two hours, the building was a mass of charred ruins. There was no loss of life, thanks to the quick thinking and speedy action of the staff who safely removed six patients to the nearby community hall. Most of the equipment was saved as well as the nurses' residence which is being used as a temporary hospital. Three weeks after the fire, plans were being made for a new 15-bed hospital of frame and stucco which will be one-storey in height, with a pent house for the matron.



Tofino General Hospital—Before

After

central authority for control of the fire-fighting activity. One might also mention the need for a well established messenger service in case of mechanical failure. Although this is the Machine Age we cannot depend entirely upon our communication systems; therefore, in case of fire it may be necessary to have a pre-arranged messenger service with several persons detailed to report to one or more centres within the hospital for duty or instruction of the control officer.

While there is much written on the subject of evacuation of patients, I do not propose to deal with it in detail. In general, many patients cannot move themselves and will have to be transported in bed or on stretchers; a certain percentage will be able to get about in wheel chairs or other conveyances; a few will require assistance in walking; while the remainder can proceed unassisted. However, there may be instances when patients might have to be transported from one floor level to another which could mean carrying them on mattresses or dragging them to safety, wrapped in blankets. The evacuation program, necessarily, would have to be planned on the basis of requirement in each area according to the type of occupancy. In fire-resistant buildings, it may not be necessary to evacuate other than certain small areas.

The fire safety program should reflect careful consideration in making the best use of personnel housed on hospital premises. In determining priority of assignments, the length of time necessary to call off-duty personnel and have them arrive at the scene of the fire is very important.

Equally important is the availability of aid from outside sources. In small communities with volunteer fire departments, the fire safety program must consider the time required to save the patients with the aid of both hospital and fire department personnel. If the hospital is located in a large community with a full-time department, the fire safety program can be designed for a relatively short period of time between the discovery of the fire and the arrival of the fire department.

In practically all hospitals, the only personnel on duty 24 hours-a-day are the nursing staff and the engineer. It follows that the chances are that most fires would be discovered by the nursing staff. Particular importance, therefore, should be placed on adequate fire instruction and training for this group.

(Continued on page 78)

A Symposium

Promoting Best Medical

1. Governing Board's Responsibilities

Keith H. Rapsey,
Chairman,
Board of Trustees,
Humber Memorial Hospital,
Weston, Ontario

IN outlining my impression of the responsibilities of the governing board concerning organized medical practice in the hospital, my views are based on experiences related to a surburban 50-bed community hospital over the 4-year period prior to its opening, and during the first year of its operation.

In surveying the fundamental principles upon which accreditation is based, as advanced by the American College of Surgeons, it is noted that the Board is endowed with heavy responsibilities and correspondingly wide powers and is in association with a "medical staff which functions as a collaborating self-appraising organization responsible to the governing Board for the details of its work". Again in the *Manual of Standardization* we note that "the Governing Board is charged with the duty of selecting its agents, including the medical staff", and that "the medical staff initiates and adopts rules governing professional work of the hospital, with the approval of the Board".

Why all this emphasis on the powers of the governing board, especially as related to the professional activity in the hospital? Surely because it is the product of the hospital's activity—the standard of medical care it gives—that is the most important single aspect of its operations. As in industry the emphasis should be on production, in quantity and quality, for the product alone justifies, requires, and makes possible the other related services of recording and accounting, advertising, financing, and so on.

These three articles are from a series of addresses presented at a hospital sectional meeting of the American College of Surgeons, held in Toronto, May, 1952.

Possibly the emphasis noted exists because lay boards may manifest a natural reluctance to concern themselves very intimately with an intangible product about which they know little and which is closely related to members of a profession as an old familiar problem; and upon these aspects of hospital operation the lay board member might mistakenly feel his time can be spent to best advantage.

In my opinion good medical staff organization is unlikely in a hospital if the board does not understand its responsibilities in the fullest sense, and does not take these duties seriously.

At the extremes of undesirable organization are (a) the board which is so domineering that staff advice is unsought and (b) the board which is unaware of its serious responsibilities and eagerly washes its hands of any contentious problem it can delegate to the medical staff.

The board of governors must let the medical staff know it expects adherence to accepted standards of organized medical practice in hospitals, and see that the staff is kept constantly aware of such standards. To expect the medical staff alone to initiate such a program is unrealistic. To expect the staff to carry out the program without firm board backing and enthusiasm is to ask miracles.

After all, staff members are physicians who are expected to take time from busy practices for regular self improvement and committee meetings, to keep complete medical records and submit these records to regular objective but critical analysis, and to accept restrictions on the scope of their professional activity.

All this is a tall order; and my experience has been that, while a great majority of the medical staff recognize the desirability of such procedures, when the program comes as board policy it is accepted as right and proper.

When the board has an interested and efficient administrator, the program can be most easily implemented. You may think undue stress has been laid upon medical staff organization but the American College of Surgeons reports that "the usual deficiency of small hospitals is staff organization which may be corrected through the united efforts of the staff and the hospital management".

United effort requires liaison between the medical staff and the board. A Joint Conference Committee is suggested but in Ontario, under the Hospital Act, the president of the Medical Staff is an *ex officio* voting member of the board. However, any medium of liaison will depend on ability and willingness to co-operate and the desire to measure up to accepted standards of hospital practice.

The foregoing has been the writer's idea of what should be done by the board to further good medical practice in the hospital. Following are a number of ways in which the ideas already outlined may be implemented.

1. Self-education of the entire membership of the board to understand its duties and responsibilities in the fullest sense.

2. Insistence on an organized medical staff and good staff by-laws. This is not difficult in Ontario since it is required by statute but possibly some hospitals pay only lip service to the

Practice in Hospitals

regulation. The board should let the medical staff know it expects rigid adherence to approved by-laws.

3. Maintenance of satisfactory liaison and representation of the medical staff.

4. Retaining a satisfactory administrator who has complete delegation of authority from the board. The administrator must be aware that quality of care is more significant than revenue and expense statements, and must also realize his desires will by no means always parallel those of members of the medical staff. Staff members have their individual situations to consider —the administrator considers only the hospital.

5. Insistence that the hospital obtain approval by American College of Surgeons or the approving body handling the accreditation program. This requirement if attained will automatically achieve most of the others, *i.e.*, sound organization, satisfactory medical records, and the regular review of professional work in hospital.

6. By requiring the medical staff organization to satisfy the board that controls exist to ensure a staff member will do only what he is capable of doing. He must not "learn" surgery at your hospital—or any other complicated procedures. The medical audit or regular monthly review of the professional work will let the member know if he does attempt such procedures that they will not pass unnoticed. With a closed staff and certification, control is easy, but usually such measures are not available in the small hospital. The substitute is good controls and constant scrutiny.

7. By requiring a medical audit. A periodic or monthly review of the professional work and statistics covering same, indicating death rate, normal tissues, caesarean section rate, infection rate, consultation rate, et cetera. Deviations from accepted standards will be clearly indicated.

8. By requiring a monthly clinical conference.

9. By requesting the results of such audit and conference to be summarized to the board, monthly, in a report.

* * * *

2. *Role of the Administrator*

W. Douglas Piercey, M.D.,
Superintendent,
Ottawa Civic Hospital,
Ottawa, Ont.

IT is interesting to note that, just as the topic "Medical Practice in Hospitals" is apportioned between three authors, with the administrator in the middle position, so it is in the day-to-day life of our hospitals. Three groups are concerned with medical practice: the trustees, the administrator, and the medical staff.

The administrator represents the trustees, as their chief executive officer, and is responsible for the carrying out of policies inaugurated by the board of trustees. He is the link between the trustees and the medical staff and, as such, his role is not passive but active. He might even be likened to the proverbial ham in the sandwich.

The trustees, the adminstrator, and the medical staff, and all others in the hospital whose relationships must be considered in the scheme of organization, have a primary obligation to the patient which must be dominant in all their activities and must serve as the touchstone for the entire plan of hospital organization. Hospitals are often compared to hotels and perhaps sometimes the administrator has been too much taken up with the hotel aspects of the institution. Good beds, good food, and proper maintenance are needs all very well in their place, but we must not close our vision to the primary reason for the existence of our institution and its primary purpose, namely good medical care. A beautiful hospital in a beautiful location does not in itself constitute anything but a show place. It is what goes on within the hospital which makes it a good hospital, a mediocre hospital, or a poor hospital. The public are impressed by much equipment, large x-ray apparatus, and many apparently busy people. But what really makes a great institution is the ideals, the training, and the vision of those who staff it. Almost any modern x-ray apparatus will produce fine results on a plate if the machine is properly operated; but intelligent interpretation of that image is what contributes to the welfare of the patient. This applies also to discrimination in the use of laboratory facilities and proper interpretation of findings.

No hospital can attain a half measure of success without a devoted and capable medical staff and no medical staff can give its best service to the patient and community unless it enjoys kindly understanding, intelligent co-operation and staunch support from the members of the board of trustees. It is in fostering understanding between the trustees and the medical staff and in seeing that the channels of communication between these two groups are open and readily accessible that the administrator plays his major

role with regard to medical practice in the hospital.

Responsibility of Organizing

With regard to the professional care of the sick, no person in the hospital can direct that care except the qualified physician; and the board of trustees delegates that responsibility and authority to the individual medical practitioner when it appoints him to the medical staff. Each physician is primarily responsible to the patient whom he is treating. In addition, by subscribing to the medical staff organization, he becomes responsible for results to the chief of his service, to the chief of staff, to the medical staff as a whole and to the governing board. He is the sole authority in ordering treatment for the individual patient and is not subject to interference but he is obligated to use all the diagnostic and therapeutic facilities available, as they are indicated, and he must be prepared to demonstrate to the medical staff that he uses sound judgment.

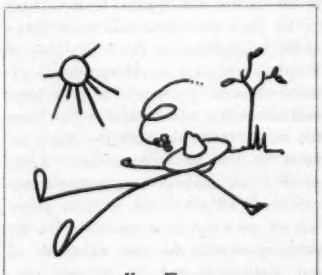
The administrator, even though he himself be a qualified physician, is not justified in interfering with the care of the patient. He must, however, be assured that this care is up to standard, an assurance which he will receive, in the well organized hospital, through the regular channels of the medical staff organization.

Following this principle, the administrator assigns personnel to the various phases of caring for the sick. These are to assist the physician in his medical practice within the hospital. The administrator instructs them either formally or tacitly to take orders for treatment directly from the attending physician. Beyond giving these orders, members of the medical staff assume no authority over personnel. If orders are not properly carried out, this is a matter which lies between the physician and the administrator and necessary disciplinary action is the duty and responsibility of the administrator. It will be seen that, in this concept, hospitals today are a field for close team work between many groups and this calls for careful organization. The spearhead in this planning and organization is the administrator.

Although, in almost all institutions, the administrator takes no active part in the treatment of patients, he must see that the patient is properly admitted by personnel who will make a favourable impression, *e.g.*, securing the necessary sociological data with courtesy and without giving offense, and assigning the patient to his accommodation promptly and with consideration. The administrator must also see that a medical staff is available and responsible for the treatment of the patient. He will, should occasion arise, prevent the carrying out of any line of treatment that is contrary to the policies of the governing board, such as illegal operations and treatment contrary to the practice of regular medicine. He is required to see that the privileges of the hospital are extended only to authorized physicians. Customarily, he is given authority to permit a known physician to attend patients until a formal appointment can be made, although the medical staff recommends and the governing body makes appointments. Definite rules for assignment, formulated by conference with the medical staff, should be made in the case of all free patients and those paying patients who apply for admission but have no attending physician.

The administrator will see that all orders for treatment are in writing, except in emergencies, and will instruct the personnel not to accept or carry out verbal orders. This is necessary to protect the patient, the hospital, and the physician, against misinterpretation, misunderstanding, and forgetfulness.

The various adjunct facilities used in the diagnosis and treatment of disease (*e.g.*, x-ray department, clinical laboratory, electro-cardiography, physical therapy, and pharmacy) are also under the control of the administrator. He selects the heads of these departments and makes such contracts as may be authorized, although he usually delegates selection of technicians and other personnel to the department head. He holds the head of the department responsible for proper functioning of the department along recognized lines and instructs him to take orders for examination and treatment from the attending physician.



Heat Wave

Responsibility of Linking

The second responsibility is to act as the link between the trustees and the medical staff. The responsibility of being a liaison officer applies to the administrator in the small hospital as well as in the large and regardless of whether he or she is medical or non-medical. It would appear that this fact is not too widely understood within the hospital field because a study of hospital by-laws with regard to the composition of medical advisory boards often reveals a clause which reads something like this—"and the administrator if he be a graduate of a recognized medical school." We all know that, once an idea appears in print, it is very difficult to have it changed and it is very often copied and recopied *ad infinitum*, without anyone seriously challenging the truth, necessity, or application of the matter to present-day circumstances. I would suggest that the clause (regarding the administrator and membership on the medical advisory board), to which I have alluded, falls in that category. If the administrator is going to be the liaison between the board and the medical staff, how can he present the viewpoint of the one to the other if he is not a member of this important group. I suggest that it is not enough that he learn the medical staff's views after their planning is all cut and dried; and I suggest further that it is a failure not to include the non-medical administrator at staff meetings and at advisory board meetings. If this is not done ultimately there are misunderstandings, friction and, sometimes, open breaks between the administration and the medical staff. The medical staff can learn much from the point of view of the administrator and the administrator can learn much from the medical staff; and the level where this exchange of views is most profitable is at the medical staff meeting, and the meetings of the medical advisory board. I believe that many of the difficulties that administrators, particularly of the smaller hospitals, have to contend with would be eliminated if they were permitted, more often than they are now, to express

their views freely at these meetings.

Responsibility of Co-ordination

It is the administrator's duty to make certain that the orders given by the attending physician to the resident medical staff, heads of departments, nurses, and all others concerned with the care of patients, be carried out unless they are in direct violation of the policies laid down by the governing body.

The administrator must co-ordinate the efforts of the departments within the organization so as to prevent any clashing of interests or overlapping of time and effort.

We must see to it that our service to the sick is properly implemented by a comprehensive program, satisfying all the reasonable demands of modern medical practice. There must be no gaps in clinical co-ordination, in laboratory service, in diagnostic aids, in convalescent care, in follow-up work, in medical social service, and in the protection of the health of hospital workers. There must be close co-operation with public health departments and with voluntary social and health agencies.

In the role of co-ordinator, the administrator must see that state and provincial acts are known and adhered to by the medical staff, and that the medical staff is aware of their obligations under these acts.

Co-operation

The fourth responsibility of the administrator is to co-operate with the medical staff in the provision of medical care to the patients. This fourth point—co-operation—is intended to imply much more than merely organizing, linking, and co-ordinating. It implies that the administrator be actively motivated to play a part with the medical staff in having the patient restored to health quickly, safely, and as comfortably as possible.

Control

This is a topic on which there has been much discussion of late and sometimes, one hears it stated that hospitals are out to gain control of the medical profession. The word control is not intended to convey that meaning here. Hospitals are complex organizations with a peculiar set-up which is not duplicated in any other organization. They are peculiar in that they contain an organization within an organization—the medical staff. The staff doctors are independent of the hospital and have no responsibility for its finances. Their professional responsibility toward the patient, like the financial responsibility of the trustee toward the donor, cannot be delegated. Such a division of responsibility is an organizational monstrosity, yet in most cases it works. The trustee lives in an atmosphere of rates and costs, deficits and money raising; the doctor deals with human life, with his own professional ambitions, and his own financial problems. Just as one has heard the statement that hospitals are trying to control the medical profession so also one frequently hears the statement that hospitals are run by the medical profession. I think it cannot be too clearly emphasized that only one group controls the hospital and that is the governing board. The administrator, as their chief executive officer, is responsible to them for everything that takes place in the hospital including the quality of medical care. A wise administrator is one who has learned that control of the medical staff can only come from within the staff itself.

The hospital of today is no longer a workshop for individual doctors. It is a field for team play and the team play is directed not towards the trustees or the administrator or the doctors or the aggregate entity called the "hospital"—but toward the patient.

A hospital is a corporation. It is a corporation chartered by the sovereign state to care for the sick, in its wards and in its out-patient department. A hospital cannot care for the sick, as the state charters it specifically to do, with bricks and mortar, with machines and equipment, with drugs and gauze, with syringes, and thermometers. There must be human hands and hearts and intelligence. There must be aides, nurses, general doctors, and special doc-

(Continued on page 74)

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3. *Professional Control in Hospitals*

William S. Caldwell, M.D.,
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IN any discussion of professional control in hospitals much depends on the general approach. To some, control will imply discipline; to others, regulation. This paper is predicated on the belief that the creation of a suitable administrative environment is all that is necessary, in most instances, for the successful ordering of staff medical services in any hospital, be it large or small.

At the outset let it be understood that while the creation of a suitable environment may be a moral responsibility of the medical profession, it is primarily the duty of the governing board. Numerous court judgments could be cited to prove that the governing board has not only the authority but an obligation to assume this task. And who will gainsay that such a task is not equal to, or of greater importance than, the provision of an adequate plant.

Personality Trends

The need of medical control may be due in part to certain personality trends which arise out of a doctor's way of life. The attitude of the general public to the medical profession is often one of great respect for and even appreciative adoration of the individual doctor, while maintaining some reserve as to the objectives of the profession as a whole, and their relations one to the other. To the hospital administrator or trustee, however, this attitude may be reversed in that there is respect for the medical staff as a whole but sometimes considerable reserve as to the objectives and habits of the individual doctor.

For the doctor is at his best when working for and with the individual patient. His hours are consumed in meeting critical situations, elucidating their cause, and piloting the afflicted one through stormy seas to quiet waters. To be successful, he must be self-confident, positive and reassuring in his advice, yet more or less lonely in the confidential nature of his task. Because so much of his work requires personal attention, his time is valuable and delays irksome. He becomes, by habit, a hardy individualist, desiring action without restraint, shunning routine, disliking the keeping of records and bowing, not always gracefully, to the edicts of authority. In short, he is

often at his work when required to function as a unit in organized effort. To this characteristic can be attributed most of the discrepancies relating to staff politics, faulty records, and neglected hospital routine.

In some instances, the circumstances which make necessary a measure of professional control arise out of practices which border on dishonesty. This does not refer, of course, to that small minority found in all classes of society who bring discredit on their fellows by deliberate acts of fraud. There are those, however, who in their zeal to learn the art of medicine or to make a success of the business of medicine, allow themselves to undertake procedures which are sometimes less than elective or which the practitioner knows are beyond his skill. Of the ten danger signals of staff deficiency listed by the American Hospital Association, most result from this lack of "Professional Conscience".

Finally it may occasionally happen that the standard of a hospital's medical service suffers through carelessness on the part of the attending doctor, or through lack of knowledge and technical skill on the part of an otherwise conscientious physician.

Regardless of the nature or cause of various medical deficiencies, can they not be removed or prevented by proper organization? Doctors generally are exceedingly jealous of their professional reputation—in the eyes of the public, their fellow-practitioners and the hospital board. Simply by making the members of the medical staff aware of their relative shortcomings, much will be accomplished towards the eradication of these deficiencies and toward an improved medical service.

Bases of Organization

Staff by-laws, organization, and clinical review are the bases of success in this endeavour. The by-laws must be complete, specific, rounded out by detailed regulations, made available to the individual staff member, and signed by him before he is granted the privileges of the hospital. In organizing, one should recognize that all proceedings of the medical staff are subject to the approval of the hospital board—though the board might well await guidance from the staff before acting on matters pertaining to medical care. Regular meetings of the staff are imperative; and reasonable attendance should be required as a condition of active or associate membership. These meetings should include an opportunity for social intercourse as an encouragement to friendlier relations and increased consultation. Primarily, however, they should be devoted to a review of the clinical activity within the hospital including the causes of deaths in hospital and reports of committees on records, credentials, and surgical tissue. The reports of these committees, to be effective, should list the accomplishments or shortcomings of each member as compared to the average. It is noteworthy that in the point system used by the American College of Surgeons in hospital accreditation, the three highest values are given for staff organization, medical records, and surgery.

Where such an organization is operating efficiently, problems of professional control seldom arise, as the delinquent member, paced by his more conscientious confreres and faced with embarassing comparison, will seek to mend his ways as a matter of self-interest.

In its own self-interest, the medical staff might well take the initiative in promoting such an organization, since the standing of a hospital reflects on the best as well as the worst and, indeed, on the profession as a whole. This is now recognized by the official medical associations from whom model by-laws can be obtained. Detailed guidance is also available from all hospital associations and from the American College of Surgeons, which has given splendid leadership in raising hospital standards since 1918.

Responsibility of Governing Board

Should the medical staff fail in this duty, the onus rests on the hospital board to insist on a properly constituted organization and to see to its continuous function. Rather than by edict, this is best done through a joint conference committee which, having representation from both the board and staff, can confer on all matters affecting the doctors and the standard of service they render. Such a committee tends to prevent that strained relationship which frequently exists between board and staff, when professional control is attempted without adequate consultation. For similar reasons, many feel that the staff should nominate by election, not only its own officers, but the clinical chiefs and a representative to the board of governors. The smaller the community, the more important does this feature become, since the more intimate associations may cause decisions to be affected by personal influence rather than by the merits of the case. The most effective manner of handling any problem relating to professional control is to have the matter dealt with confidentially by the credentials committee, then by either the medical staff or the joint conference committee and, finally, in the few cases not already resolved, by the board of governors.

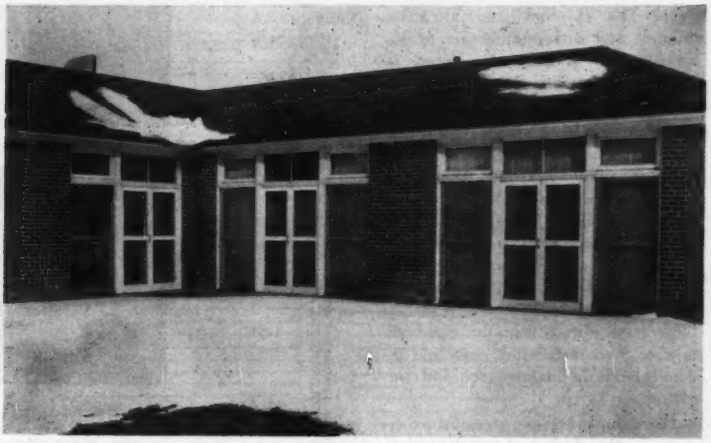
Joint Fees

Unfortunately, this discussion may not be closed without some reference to the ethics of joint fees. In its more sinister forms it can be damaging to the standard of hospital practice. The American College of Surgeons advocates that in the pledge signed by a prospective member of a hospital staff there be included an agreement to refrain from the division of fees. Most staff members will approve of this policy if "fee-splitting" is defined as rewarding another for referred work. But it must be reported that among honest and conscientious doctors there is a good proportion—and in the case of general practitioners, probably a majority—who believe that medical services are not harmed by a joint fee, provided (1) the patient is aware of a division and (2) the division is on a basis of actual service rendered. As arguments in favour of this position, it is stated that patients prefer a composite fee, that it tends to resolve the admitted discrepancy between surgical and medical remuneration, and that it minimizes bookkeeping and collection expenses. On the other hand, it must be admitted that joint fees do widen the opportunities for unscrupulous practices and, because of this, hospital policy might well lend its support to the reform.

In this, as in all matters of hospital staff reform, reason is the instrument by which real progress is to be achieved. Doctors should be and, for the most part, are amenable to sound logic. Daily they apply themselves to relating cause and effect. Given an opportunity for study of medical staff problems and some incentive to measure up to a standard, they will react like any other group of intelligent human beings by applying themselves to to the attainment of the desired end, by means of self-discipline. ●

Radiant Heating System

at St. John's Convalescent Hospital



A belt of vermiculite concrete between floor slab and wall prevents loss of heat, through conduction from heated slab, through outside walls to cold ground. As shown in the picture above, no snow is melted around the outside of the building.

W. M. Prentice, A.S.H.V.E.,*
Toronto, Ont.

THE use of radiant panel heating in residences and institutions, as well as in commercial and industrial structures, is receiving preference over conventional means in ever-widening fields of applications. The general performance of this system of heating results in an increasing appreciation of its efficacy.

The practical application of panel heating is, of course, not new. An English writer, Berman, published a book in 1845 in which he gave a detailed description, with sketches, of many of the hypocausts found after excavation of Roman ruins in Britain, dating from the occupation. In those buildings the main floor of the room to be warmed was built on stone columns leaving a space 18 to 24 inches in height in which a fire was lighted, the smoke and gases passing up a flue at the opposite end of the room. As this smoke passage was small, the hot gas spread under the entire floor, resulting in a fairly even distribution of heat. With the decline of the Roman Empire and withdrawal of its legions from Britain, so went the use of panel heating, to remain dormant until early in the present century.

The main entrance of the hospital showing typical window arrangement. Despite wintry weather, note open vestibule door and windows.

Possibly the earliest use of panel heating in a Canadian hospital is that of the 100-bed public ward wing of St. John's Convalescent Hospital, in the Newtonbrook district, north of Toronto, Ont. (For a description see *The Canadian Hospital*, May, 1952.)

The main building, erected in 1926, is of conventional design heated by steam, using standard pattern, cast-iron radiators under the windows. Modern architectural trends, however, coupled with present-day thinking in restorative therapy have, in the new 100-bed wing, resulted in the use of large expanses of glass extending from the

**Mr. Prentice is with the firm of Mathers and Haldenby, Architects, Toronto.*

floor. The spacious and attractive grounds and surroundings are of absorbing and stimulating interest to the patients; virtually every native Canadian bird may be observed in season, many pea-fowl being permanent residents.

Large windows rising from floor level have always provided difficulties for the heating engineer. Many schemes, involving floor-recessed convectors, such as forced warm-air under floor ducts, have been employed with varying degrees of success. However, these have always had the disadvantage of high installation costs and inconvenience in maintenance and servicing.

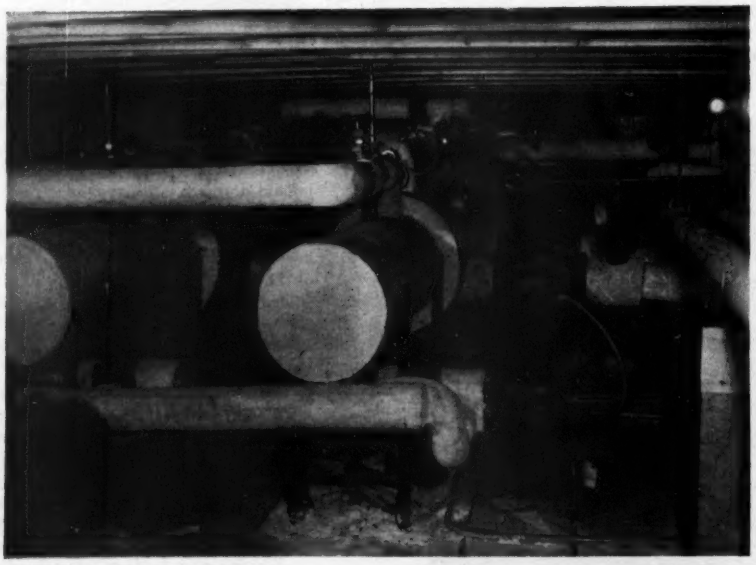
Based on previous successful experience in the design of panel heating, the architects for St. John's Convalescent Hospital, Mathers and Haldenby, recommended its use to the hospital board. After several months of detailed investigation and observation by the author, the board accepted the recommendation to provide this form of heating by the use of floor coils.

A brief explanation of the principle of radiant heating may assist one to appreciate its mechanical advantages and assess its utility.

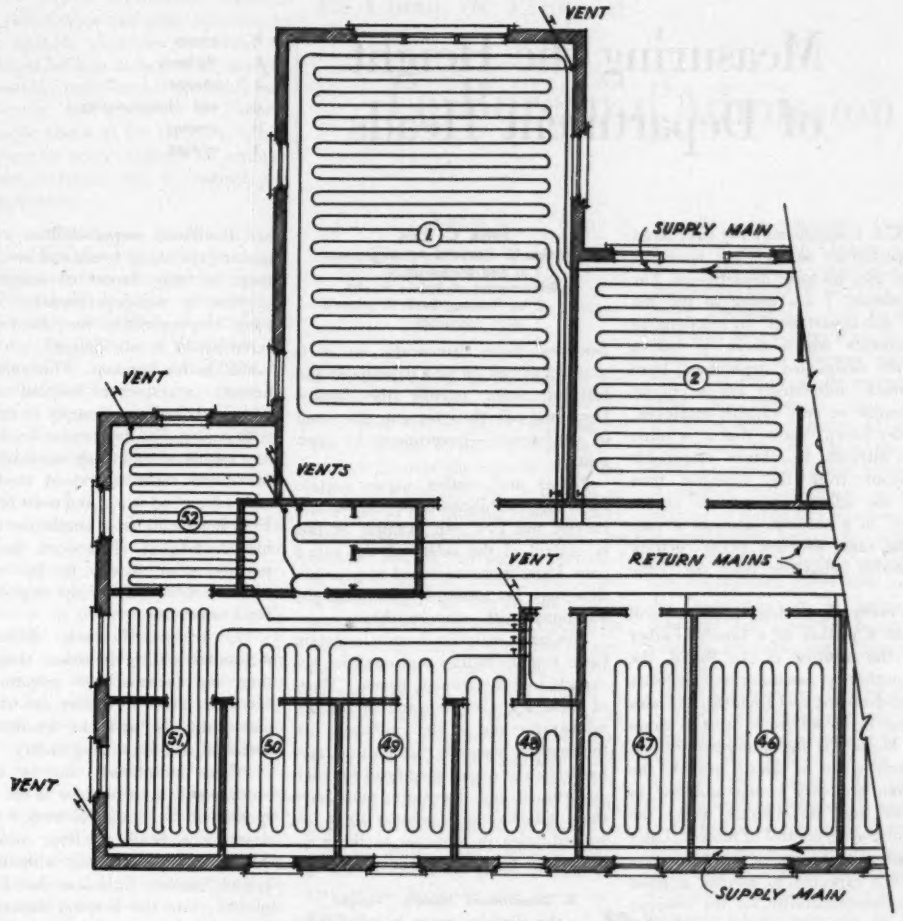
The four small circular plates shown in the floor cover balancing valves controlling the warm water flow in each room. A screw driver adjustment alters the rate of flow to suit the room requirement. It is seldom necessary to make any further change once the setting has been made.

The purpose of heating any building is to create a condition in which the human body relieves itself of its excess heat, at a rate conducive to comfort—i.e., if the room is too cool, one's body heat is lost too fast, or if the room (or the sun) is hot, heat is not passed off quickly enough and, in either case, one is placed in a condition of physical, as well as mental discomfort.

The conventional means of comfort control is to maintain the temperature of the room air at about 70 degrees F. However, in radiant heating, panels, within the floor, ceiling, walls, or combinations of these, are warmed to a temperature at which heat waves of correct intensity are emitted, which,



This plant, containing steam-to-water convertors, automatic steam regulators, hot water circulating pumps and associated piping, valves and traps, is located in the four-foot-high attic space. Apart from the usual checking of electric motors and steam traps, this equipment requires no attention.



Typical Layout of Floor Coils in Public Ward Wing.

impinging upon the body, regulate the heat loss. Thus comfort is maintained, even though the ambient air temperature may be considerably reduced.

The use of ceiling and/or wall coils have certain advantages over the floor location. However, the higher cost of the former methods and the belief that ambulant patients would be best served by a warm floor, were deciding factors in favour of floor coils.

There is nothing of an unusual nature embodied in the design. The new one-storey addition is built on the ground, without a basement, and has nine-inch walls. The concrete floors are covered with linoleum or mastic tile, with terrazzo in main entrance and service rooms. There is a three and one half-inch, rock wool type of insulation over the entire ceiling but not in the walls. Windows are double-glazed. The total heat loss is calculated between 10 to 75 degrees F. and includes 10 per cent for exposure and 50 per cent for air change.

The floor coils are of standard welded-joint black iron pipe in sinuous form throughout; each room and ward having an individual coil and heat control valve. The building is further divided into four zones, piped separately, each having a circulating pump operated by its zone thermostat, room temperature being controlled by the starting and stopping of the pump. It must be said that this arrangement is not the best means of control but, because of the usual limitations imposed by the shortage of funds, this method was used. A system of warm water blending, actuated by an outdoor control is preferable.

The water-heating plant consists of two steam convertors located in the attic space at the centre of the building. Steam is supplied from the main boilers, in the older building, and automatically regulated to maintain a fixed water temperature in the coils. A feature of the installation is the use of insulating concrete, between floor and wall, which effectively prevents the rather high conduction of heat to the outside, heretofore found when heated

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Measuring the Height of Department Heads

H onesty
E fficiency
I nterest
G ood Housekeeping
H armony
T raining

John C. Lee,
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SMALL hospitals may not have large departments as such but none the less they do have departments. For convenience, I am going to use the term "sub-department" in referring to departments where there is not a formally designated department head but which undoubtedly are in charge of a senior or very capable employee.

Every parent knows that it is often more difficult to obtain reasonable behaviour from the youngest than from the adolescent member of his family. In a hospital, small as it may be, the same problem exists—getting reasonable behaviour from the "little ones".

To carry my analogy further, I will present a picture of a family. Father is in the position of the Board, the final authority, assuming responsibility for fund-raising and finances, and also serving in an advisory or staff capacity. Mother is the administrator. At an early stage in family growth, the children are very young and few in number and are directly under the administrative control of mother. Later on there may be one or two teen-agers who are expected to assume a good deal of responsibility for the younger ones. At times the responsibility for certain young ones will be assigned directly to each teen-ager. At other times one teen-ager may be expected to be responsible for all.

Th process of growth and improved organization in the family structure is slow and requires constant effort on the part of both father and mother. The shifting of responsibilities to the older children is accomplished over a period of years. This is done by teaching certain duties, by example in the duties and by specific direction. After a while guidance of the child becomes more democratic as it is possible to call on past experience and learning from outside the family. Decisions can then become the result of conferences—government by committees.

Father and mother expect certain basic responsibilities to be learned and carried out first. An example of this is control of the safety of the young ones. Later more advanced responsibilities may be assumed, (for example, assistance with schoolwork).

Similarly, in your hospital, certain basic responsibilities and qualities are expected of department heads. Many of these are also required in the administrator and in the employee. In the smallest hospitals the administrator has to be the department head for each department and, therefore, must have these qualities and assume these responsibilities in addition to those required for the administrative role.

A Department Head's "Height"

In the slightly larger hospital these are the basic responsibilities of the senior department heads and are, what they, in turn, expect of senior employees in sub-departments. These basic responsibilities may be remembered by the word, "height".

John C. Lee

"H" is for honesty. This refers to honesty in respect to hospital money and goods and also honesty in dealing with people. The department head must be capable of admitting responsibility for errors, able to extend credit to others for good work, and must refrain from borrowing from employees under his supervision. This word, honesty, typifies what should be the whole ethical relationship of the department head to others.

"E" is for efficiency. Efficiency means the ability to reduce waste of time and materials, to prepare and carry out plans for better use of time and materials, and the qualities of foresight and organizing ability.

"I" is for interest. Interest in the work which is to be done is the chief quality of the successful worker be he department head or floor polisher. Ability is necessary but without sustained interest little can be accomplished. For the hospital department head this can take the form of study of problems, research or practice of methods. Interest can also be seen in the attention given to good supervision, to the encouragement of employees, and in helping employees with personal or working difficulties.

"G" is for good housekeeping. Every department of the hospital should be neat and clean at all times. The housekeeping staff cleans all areas used by patients alone or by staff and patients in common. The department head must see that areas which are used chiefly by his own staff are kept clean and orderly. Good housekeeping within the department also means that equipment should be kept clean, well lubricated, and in good repair. Parts of the building (for example, walls, floors, plumbing and electrical fixtures) and furn-

(Concluded on page 70)

An address presented at an institute for hospital administrative personnel, held in Regina in November, and Saskatoon in December, 1951, sponsored by the Saskatchewan Hospital Association, the Saskatchewan Registered Nurses' Association, and the Saskatchewan Department of Public Health.

Le Coeur de l'Hôpital

Le Bureau d'Admission

Partie II

Soeur Jeanne-Mance,
R.H., I.L., M.A., M.T.,
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LE bureau d'admission, dans un hôpital, est fait pour admettre les malades pour les accueillir, les aider et les hospitaliser. C'est son premier rôle, mais aussi il est établi pour procurer des ressources à l'hôpital puisque c'est à lui que revient le soin de régler tout ce qui regarde les arrangements financiers avec les patients qui se présentent.

L'Uniformité des Prix

Nos hôpitaux coûtent cher et chacun de leurs services absorbe des sommes considérables. Pour se procurer les ressources nécessaires à la bonne marche de l'hôpital, il faut bien les demander à ceux qui bénéficient de ses services, j'entends les clients de l'hôpital. Je vous parlerai de l'uniformité des prix à l'hôpital, (a) de l'importance de l'uniformité des prix; (b) de sa nécessité; et (c) de son application.

Importance. L'uniformité des prix est un facteur de progrès dans un hôpital pour bien des raisons et surtout parce que cette politique écarte la tentation de donner des services quelconques à rabais, de couper sans raison les prix convenables, de dimuner sur des choses essentielles, de garder un personnel inexpérimenté et sans compétence reconnue. Lorsqu'une institution est assurée d'un revenu honnête et est à l'abri d'une concurrence déloyale, elle est encouragée à s'installer le mieux possible et à développer ses services, tandis qu'autrement une institution végète et elle craint de faire les dépenses qui s'imposent, pour ne pas assumer des charges trop lourdes. Et dans ce dernier cas, c'est le public qui y perd.

Nécessité. Non seulement l'uniformité des prix dans une localité est importante, désirable, elle est, pensons-nous, nécessaire—surtout pour couper court au marchandage et pour protéger les clients de l'hôpital. Qui n'a expérimenté les difficultés que l'on rencontre parfois à faire payer les services hospitaliers? Le patient qui retourne chez lui ne s'explique pas toujours les exigences de la maison qui l'a soigné et guéri; il est incapable d'évaluer ce qu'il a coûté à l'hôpital en frais de toutes sortes; il ignore que, de la plus humble employée jusqu'au médecin-chef, tous les membres du personnel ont apporté une contribution. Tout cela doit se payer évidemment. Les trifs des services professionnels, ceux de l'avocat, du médecin, de l'infirmière ne s'évaluent pas facilement en chiffres, ils ont quelque chose d'élastique parce qu'ils contiennent un élément humain, un apport personnel de dévouement, de coeur. Ainsi en est-il de l'hôpital, les services qu'il rend sont difficiles à apprécier en signes de dollars. Cependant la prudence ne permet pas à nos institutions de sa désintéresser tout-à-fait du côté financier. Il leur faut exiger un paiement pour les soins qu'elles ont donnés. Et il sera bon que le tarif exigé soit à peu près le même dans toutes les institutions du genre. Ainsi on évitera les ennuis qui accompagnent les réclamations, les malentendus. Le patient qui retourne guéri acceptera mieux de payer la note s'il voit qu'elle n'est pas plus élevée qu'ailleurs.

Application. Ces généralités étant connues, venons-en à l'application. Le tarif uniforme s'étendra d'abord aux lits et aux chambres de l'hôpital. Récemment le Conseil des Hôpitaux de Montréal a prié le Ministre de la Santé d'augmenter la somme qu'il accorde à l'Assistance Publique en vue d'aider les indigents qui viennent à l'hôpital. Actuellement, un lit d'hôpital revient a $10.82 par jour, et dans certains endroits bien au delà; mentionnons le Royal Victoria Hospital où le coût d'une journée d'hôpital était de $9.95 en 1948, ce qui dépasse beaucoup la somme qu'on nous octroie pour le traitement de ces malades. Il nous faudrait recevoir davantage. Le gouvernement consentira-t-il à faire droit à nos demandes? Nous le souhaitons. Depuis septembre 1948, dans la plupart des grands hôpitaux, le prix d'un lit de salle a été augmenté d'un dollar, soit $5.00 par jour. Comme la plupart des assurances en maladie accordent un montant de $5.00 par jour, il arrive assez fréquemment que les malades préfèrent se contenter d'un lit de salle pour éviter des charges supplémentaires. Cet état de choses ne va pas sans créer un problème pour certains cliniciens qui se plaignent de cette répartition des lits dans une même salle: Assistance Publique, Croix Bleue, et caetera. Actuellement, y aurait-il avantage à établir une sélection ou bien le professeur habile et délicat ne pourrait-il pas demander également à tous ces malades, même sous le régime de l'assurance, de se prêter à la clinique? Les nouvelles constructions aideront probablement à résoudre ce problème.

Pour les chambres, le tarif n'est pas facultatif; il est établi par voie de comparaison. On tient compte à la fois de l'espace, de l'endroit et du confort accordés par l'hôpital. Le prix est fixé d'après ces données. Il appartient au Bureau d'Admission de déterminer, dès la première entrevue avec le malade ou la famille, le genre d'hospitalisation et le mode de paiement. Ces renseignements transmis ensuite au Bureau des Comptes, lui feront connaître l'engagement précis et détaillé pris par la famille pour solder le compte de l'hôpital.

Le Collège des Médecins et Chirurgiens a réimprimé dernièrement la liste des tarifs applicables soit (1) aux médecins dans le cas des différentes opérations majeures ou mineures, (2) aux laboratoires, pour chacune des analyses pratiquées, (3) aux rayons x pour les examens plus communément utilisés: les fractures, tube digestif, cholécystographie orale ou intraveineuse, et caetera. Notons cependant que la liste de ces prix ne nous intéresse qu'en ce qui regarde la salle d'opération proprement dite et non quant aux honoraires du médecin.

D'ordinaire, le patient des salles ne paie que la moitié des frais exigés dans les chambres privées. C'est un usage

Ce conference est la seconde d'une série donnée à Montréal et à Québec en 1950-51, lors des Cours d'administration Hospitalière, Comité des Hôpitaux du Québec. A ce temps, Soeur Jeanne-Mance était Administratice, Hôtel-Dieu de Montréal.

général. Cependant, il arrive que le patient des salles reçoive de la part des anesthésistes, des chirurgiens et des médecins, des comptes comme on présente aux malades des chambres semi-privées. Il appartient alors à la direction de l'hôpital de prévenir ces écarts en établissant un barême uniforme, obligatoire, et de protéger ainsi et les malades et les médecins contre un semblant d'exploitation.

Les Analyses

Voilà un domaine où l'uniformité serait à désirer. Des hôpitaux ont fixé un prix global (flat rate) pour les analyses de routine: urine, urée sanguine, glycémie, cytologie, B.W. ou autres. Avant d'adopter cette méthode, il faut demander aux médecins ce qu'ils entendent par analyse de routine. Ainsi en chirurgie, les analyses de routine comprennent: urine c.m., pH urinaire,—urée sanguine,—glycémie,—cytologie, — prothrombine, — facteur Rh,—groupe sanguin,—bromsulfaléine ou acide hippurique—B.W. et en urologie, on ajoute à celles déjà mentionées en chirurgie, un test pour la valeur fonctionnelle du rein: Van Slyke et pour la perméabilité: P.S.P. et parfois division des urines. Et les autres spécialitiés?

La chirurgie vasculaire par exemple: sympathectomie, laquelle requiert des analyses spéciales: chlorures: sang total et plasmatique, Na, K, et caetera, la cardiologie, la médecine générale, demandent aussi certaines recherches appropriées. (L'administration de l'A.C.T.H. et de la cortisone demandent la recherche des chlorures, 17-ketostéroides, et caetera.) Et que penser des médecins qui demandent des electrocardiogrammes pour tous leurs patients en salle et n'en demandent à peu près pas en chambre privée!

L'exécution de ces analyses exige une préparation longue et soignée de médecins et de techniciennes. Leur nombre est tellement considérable et varié qu'il nécessite de l'espace, du temps et des connaissances de la part de ceux qui les pratiquent. Cest analyses évidemment sont dispendieuses. Cependant si l'on pèse les sérieux avantages qu'elles procurent, le service qu'elles rendent dans le dépistage des maladies et dans l'établissement du diagnostic, personne ne refusera de payer ce qu'elles valent.

En effet, quel progrès magnifique s'est accompli dans les laboratoires depuis quelques années! Le nombre des analyses a plus que quintuplé. Ainsi dans un hôpital par exemple, les statistiques nous apprennent qu'en 1930, il se pratiquait 21,008 analyses, en 1940, 46,142 analyses, en 1946, 85,744 analyses et en 1948, 107,073 analyses, et cela sans compter l'histologie. Il va sans dire qu'un tel nombre d'analyses exige un personnel plus nombreux et mieux qualifié de médecins et de techniciennes et, partant des dépenses plus grandes en fait de traitement et de salaires. Les rayons x, la pharmacie, et caetera, doivent aussi faire leur part pour fournir à l'hôpital tous les moyens modernes et scientifiques qui lui assureront le meilleur rendement.

Rayons X

La radiographie est un item qui est souvent l'objet de critique de la part du patient lorsque ce service n'est pas remboursé par les assurances. On est porté à perdre de vue l'immense service que rend aux malades un département de radiologie bien organisé. Les spécialistes qui consacrent leur vie à cette étude profonde et scientifique méritent bien de la part des administrateurs les meilleurs encouragements. Et l'hôpital qui sait maintenir un haut standard de cet important service n'a qu'à se féliciter. Il lui est souvent redevable de la découverte des maladies et de plus de sûreté et de précision dans les diagnostics. Les traitements de radiothérapie et de physiothérapie relèvent aussi de ce département, qu'il s'agisse d'examens ou de traitements, il faut s'arrêter à un tarif raisonnable après entente avec l'Association des Radiologistes, en tenant compte évidemment du coût de l'installation des appareils, de leur entretien, des frais d'amortissement, sans oublier de protéger le patient contre des prix parfois exorbitants qui ne manquent pas d'exciter ses récriminations.

Oxygénothérapie

Ce traitement à l'oxygène est administré soit par cathéter nasal, soit à l'aide d'un masque (oronasal) ou d'une tente. Les médecins prescrivent généralement de 6 à 10 litres à la minute sous la tente et de 6 à 8 litres par le masque. Ces détails montrent que le traitement en question ne peut être administré et surveillé que par des personnes compétentes et capables de suivre exactement les prescriptions du médecin. Elles devront tenir compte à l'aide du manomètre, et de la quantité utilisée par le patient et de la durée du traitement de manière que la caissière puisse établir ses factures en conséquence. C'est surtout le facteur "temps" qui nous intéresse et le "mode" d'adminstration. Le prix de ces traitements est le même en général dans tous les hôpitaux qui l'emploient.

Pharmacie

Un centre de non moindre importance est bien la pharmacie. Ses prix doivent être comparables aux autres hôpitaux puisque les fournisseurs sont généralement les mêmes. Une liste complète de tous les médicaments et remèdes ainsi que leurs prix respectifs doit être à la disposition des pharmaciens pour éviter bien des discussions sur le manque d'uniformité. Dans les comptes remis aux malades, il est à conseiller de ne pas inscrire quotidiennement à son état de compte le montant minime de certains médicaments tels que: sonéryl, séconal, aspirine, cibalgine, hématinic et foie, iodaminol, mais de bien s'entendre avec les surveillantes d'étage pour que ces dernières enregistrent régulièrement et à date précise sur une pièce justificative spéciale, tous ces différent items et les fassent parvenir au bureau des comptes toutes les semaines et sans contredit au départ du malade. Etant donné que dans la plupart des hôpitaux on possède une machine enregistreuse, on doit donc lui faire atteindre son but, celui de diminuer le travail tout en donnant un meilleur rendement.

Il existe plusieurs pièces justificatives et c'est encore aux officières de département que revient la fonction de les utiliser à propos. Cette exactitude et cette précision à remplir intelligemment ce simple papier ont une répercussion et sur le malade et sur l'opératrice de la caisse merveilleuse.

Il évite aux malades l'ennui de voir un item comme le suivant:

Pharmacie	0.40
Garde-malade	0.50
Saluté	1.25
Pansements	0.50
Divers	0.25

mentionné plusieurs fois, tandis que quelques jours réunis sur une même facture semblent satisfaisant. Quant à l'opératrice, son travail est considérablement diminué. Au lieu d'inscrire chaque jour tous ces items sur l'état de compte du client, elle opère une seule fois, les montants étant additionnés, ce qui simplifie l'état de compte et permet de présenter une seule feuille au lieu de trois, et dispose mieux le

(Continué sur la page 68)

First Summer Classes of C.H.C. Extension Course in Hospital Organization and Management

at Kingston

The first two summer classes of the Canadian Hospital Council extension course in hospital administration were held at Queen's University, Kingston, Ont., from June 2nd to June 27th and at Regina College, Regina, Sask., from July 14th to Aug. 8th.

The students at Kingston were, in front row, left to right: Mrs. Margaret MacLean, Glace Bay, N.S.; Sister M. Magdalen, Cornwall, Ont.; Sister Mary of Good Counsel, Charlottetown, P.E.I.; Sister Mance Decary, Montreal, Que.; Sister Clora M. Skidd, Chatham, N.B.; Sister Mary of the Assumption, Kingston, Ont.; John E. Manning, Toronto, Ont.; L. C. Farris, Kitchener, Ont.

Second row, left to right: J. B. A. Mickie, Ste. Anne de Bellevue, Que.; J. G. Cawthorpe, Toronto, Ont.; G. H. Shaw, Ste. Agathe Des Monts, Que.; Brock H. Payne, North Bay, Ont.; H. K. Krafft, Sarnia, Ont.; Lieut. S. T. Richards, Ottawa, Ont.; Dr. W. I. Taylor, Ottawa, Ont.; Paul Olivier, Lac Etchemin, Que.; C. W. Hoddinott, St. John's, Nfld.; H. F. Garwood, Niagara Falls, Ont.

Pictured at Regina are, front row, left to right: Miss C. A. G. Gadd, Cold Lake, Alta.; Sister M. Honora, Winnipeg Man.; Sister M. Angelus, Oliver, B.C.; Sister Agathe-de-jesus, Vancouver, B.C.; Miss Noreen Flanagan, Medicine Hat, Alta.; Major Gladys Gage, Winnipeg.

Second row, left to right: Dr. K. S. Ritchie, Vancouver, B.C.; H. R. Slade, Powell River, B.C.; A. MacLean, Portage La Prairie, Man.; W. C. Hibbert, Wadena, Sask.; H. P. J. Gunn, Vancouver, B.C.; E. F. Macdonald, Penticton, B.C.;

Third row, left to right: J. E. Ledgerwood, Swift Current, Sask.; D. C. Stevenson, Prince Rupert, B.C.; A.S.L. Corner, Nanaimo, B.C.; S. V. Pryce, Calgary, Alta.; M. F. Kushnir, Canora, Sask.; H. R. Thompson, Yorkton, Sask.

at Regina

Food and Its Service

Sponsored by
The Canadian Dietetic
Association

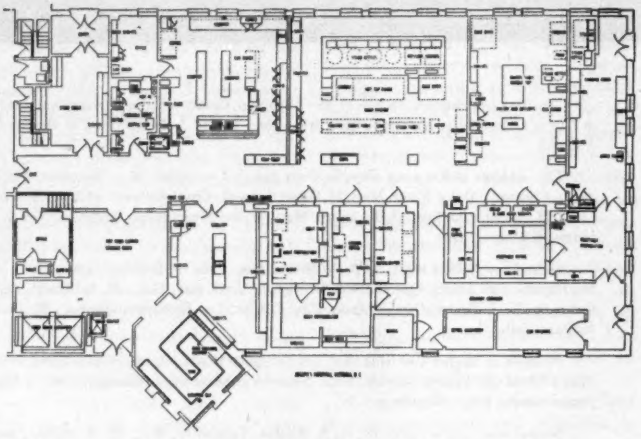
Award-winning Kitchen at St. Joseph's Hospital Victoria, B.C.

IN 1949 St. Joseph's Hospital, Victoria, B.C., opened one of their new units, the ground floor of which is occupied by the main kitchen and the special diets department. These units are large and represent a considerable addition to the floor space formerly assigned to them. The area of the main kitchen is 4,516 square feet and that of the special diets kitchen is 1,745 square feet.

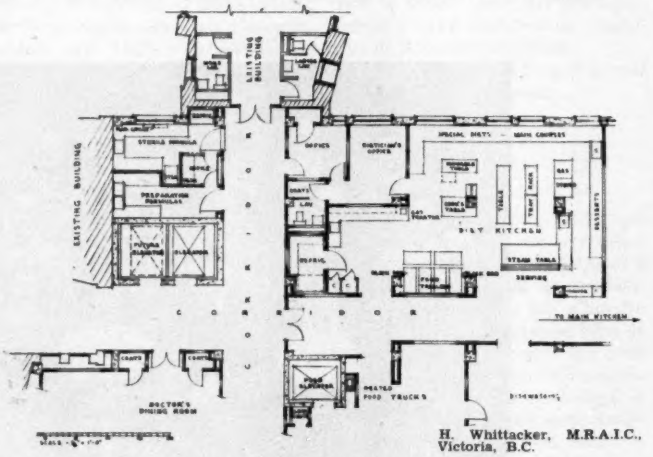
The dietetic department has brought special honour to St. Joseph's Hospital. In 1950, *Institutions Magazine* presented the hospital with a plaque in recognition of its efficient food service. This was the first such award bestowed upon a Canadian hospital.

The main kitchen and special diets department operate independently although in close co-operation with each other. The main kitchen is under the management of an experienced Sister Supervisor, whose duties consist of purchasing food supplies for the entire institution; planning the menus; and overseeing the preparation of the regular diets and the distribution of staples from the main stores. All regular diets and the distribution of ment and sent to the nine main ward kitchens by means of food wagons. A copy of the week's menu is supplied to each ward, to allow the supervisors and head nurses time to order any "extras" needed for patients who, while not on a prescribed diet, may occasionally require a variation from the menu of a particular day. They also requisition from the food stores whatever quantities of bread, milk, butter, et cetera, they require for the day.

The staff of the main kitchen is composed of the supervisor, three chefs, a butcher, six other men, and two women. The butcher cuts and trims all the meat required for the day's menu. A chef cooks it and dispenses it to the heated carriers for each ward. The second chef prepares the supper courses, makes salads, and serves them to the wards. The third or pantry chef, with a female assistant, makes the



Main Kitchen



H. Whittacker, M.R.A.I.C.,
Victoria, B.C.

Special Diets Kitchen

cakes, puddings, and pies.

Special Diets Department

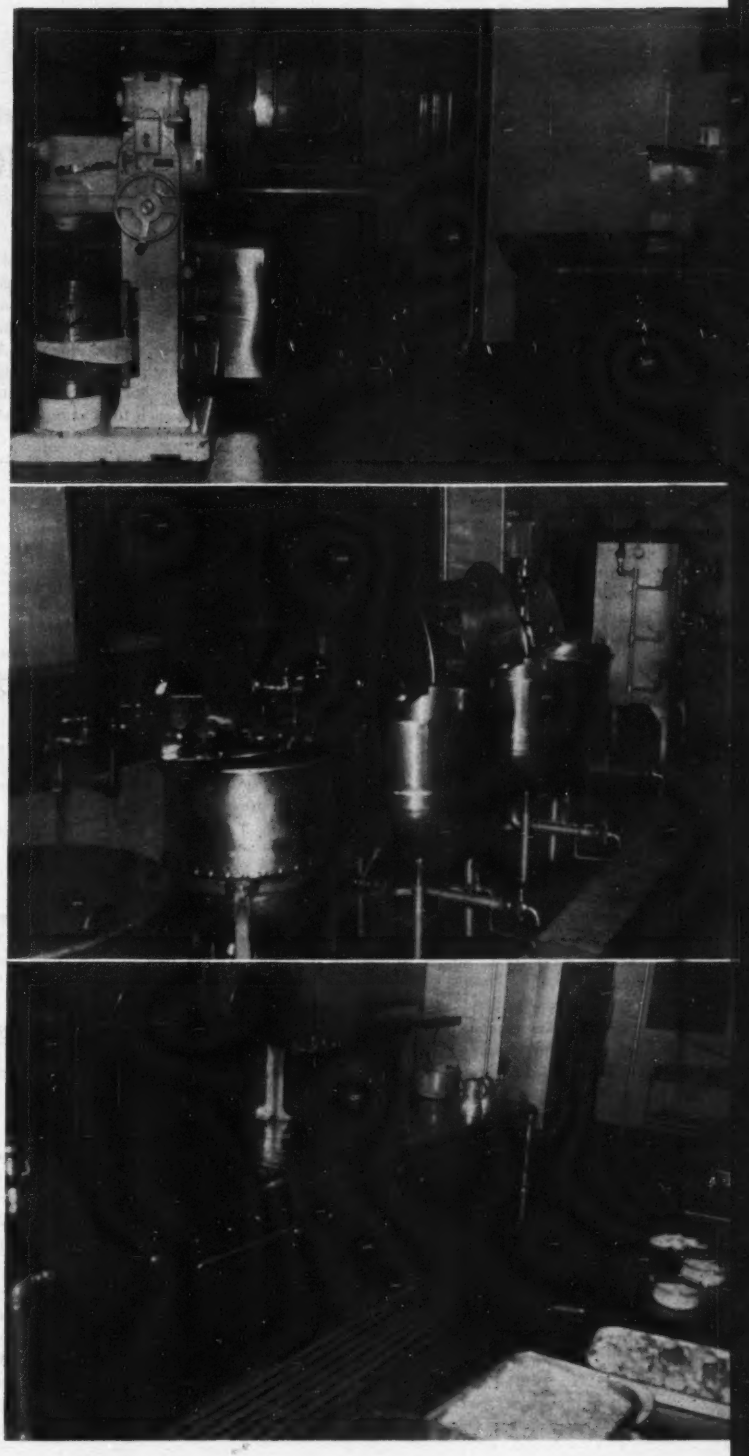
The special diets department is under the supervision of a head dietitian and her assistant. Besides the permanent staff, the student nurses rotate in this department and receive detailed instruction in the preparation of food for patients for whom a special diet is medically prescribed. The dietitian also gives the class room lectures in dietetics to student nurses and conducts the dietetics laboratory course connected with these lectures. She visits the patients who are served from her department, and confers with the doctors regarding any problem arising from their reaction to the diet ordered.

The main kitchen is equipped with two deep freeze units and five walk-in refrigerators, one for each separate class of food. It has the latest labour-saving devices such as, steam tables with separate compartments, and a metal cook table with built-in sink. There is a four-unit gas stove with roasting oven and two electric ovens for baking. There are two 40-gallon and two 30-gallon steam-pots, one roasting steamer, and one pressure cooker. Smaller items of great use are the meat slicers, meat and vegetable choppers, potato peeler with metal sink, 20-quart cake mixer, two 80-quart cake mixers, and adequate electric toasters. The coffee is made in three 12-gallon coffee units. The meat room is equipped with double metal sinks, and convenient, modern meat block with a sinew-puller. The marble-topped baker's table contains bins of 100-lb. capacity for sugar, et cetera.

The diet kitchen has its own walk-in refrigerator, steam-table, ice-cream freezer, cake mixer, and electric toaster.

The kitchens are air-conditioned and, therefore, canopies are not necessary to carry off fumes from cooking.

The Sister Supervisor and head dietitian each have an office where they can plan their work, check their accounts, and interview staff and commercial agents. — *Sister Mary Rose.*



Above: The spacious bake section.
Centre: Vents are connected directly to the stock kettles. Hot and cold water is available at each set of kettles, as well as steam.
Below: Cooking odours are drawn off through vents on range back. Ranges are constructed for easy cleaning, with grease traps readily accessible.

General Standards for

Construction of Nurses' Residences

THE standards set forth herein are recommended requirements for construction of nurses' residences for which aid is sought under the federal hospital construction grant. They are issued in an effort to ensure that reasonably good facilities are available in nurses' residences. The payment of such grants by the federal government involves a responsibility upon it to see that the accommodation is satisfactory. In determing these standards it was found necessary to make some items mandatory and they are noted as such where they occur. Other items are included as desirable to assist hospital boards and their architects in determining their needs.

Standards prepared by the Hospital Design Division, Department of National Health and Welfare, Ottawa.

Preparation of Plans

Plans of projects for nurses' residences, which are submitted to provincial authorities in order to obtain a federal construction grant, must conform to the following:

(a) Plans shall be drawn to a scale sufficiently large to present clearly the proposed design.

(b) They shall designate areas and rooms indicating, in outline, fixed equipment and all furniture proposed in the standard nurses' bedroom of various types (*i.e.*, single or double rooms).

(c) It is most desirable that final, approved, sketch plans be submitted in order that any changes required can be made prior to working drawings being undertaken.

Fire Prevention

(a) No nurse shall be accommodated above the second storey above grade, if the building is constructed wholly or mainly of wood, unless it contains an approved sprinkler system throughout.

(b) Suitable fire exits and fire escapes approved by the Provincial Fire Marshall shall be provided for each nurses' residence.

Nurses' Residence

It is desirable that a nurses' residence be a separate building connected to the hospital by a tunnel or corridor. This building should contain a large living room and a small reception room or rooms depending upon the number of nurses to be housed. A small kitchenette adjacent to the living room is desirable for entertainments and a pantry on each floor should also be considered.

The following rooms and areas are usually required for a residence, particularly if there is a school of nursing.

1. Entrance, hall with information desk telephone;
2. Office for director of residence;
3. Men's coatroom and toilet;
4. Large reception room (15 sq. ft. per nurse);
5. Small reception room (s) — approximately one per 30 nurses;
6. Kitchenette;
7. Recreation room;
8. Storage room for trunks—one per floor desirable;
9. Ironing room (one floor for larger residences), including laundry tubs;
10. Pantry, one per floor (desirable);
11. Infirmary with necessary utilities (for larger residences);
12. Linen room and janitor's closet on each floor.

Nurses' Accommodation

The mandatory minimum floor areas for nurses' rooms are: single room—110 square feet (includes cupboard space); double room—180 square feet (includes cupboard space); and minimum width—8 feet.

The furniture required in a nurses' room is as follows: single bed (standard domestic—6′, 7″ x 3′ or built-in beds with storage area underneath to save space); bed-side table (desirable); desk*; dressing table* and mirror; straight chair; lounge chair (desirable); book shelves*; waste basket; clothes closet plus space for shoes and hats; lavatory basin (desirable); floor lamp (desirable).

Dormitories are unsatisfactory because studying would be difficult. Federal assistance is given only for single and two-bed rooms.

Accommodation below grade is most undesirable; hospitals with this type of accommodation will experience great difficulty in retaining staff. However, if insisted upon, no nurses' bedroom shall be considered for grant purposes when the basement floor is more than 3′, 6″ below grade, where there are bedroom windows.

Separate rooms are advocated because of the problem of nurses on night assignment.

Plumbing Fixtures

The following are the minimum requirements for plumbing fixtures: toilets—1 per 6 nurses; showers or baths —1 per 6 nurses; lavatory basins—1 per 6 nurses (when not included in bedrooms). The above proportions do not include fixtures serving a private room.

Teaching Facilities in Nurses' Training Schools

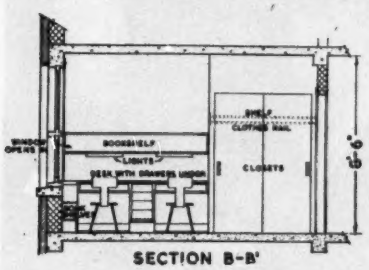
Teaching facilities should include:

1. Sufficient small offices for the director of each faculty;
2. science laboratory;
3. dietetic laboratory;
4. nursing arts classroom;
5. assembly hall to accommodate total student body;
6. one library;
7. toilets, storage, janitor's closets, hanging space for nurses' capes with pigeon holes for students' books.

The laboratories and classrooms should be large enough and sufficient in number to take half the entering class. It is desirable that each room should not accommodate more than 16 students, which is the maximum number that one instructor can properly teach.

* *Could be built-in furniture.*

Room Layouts Suggested by Hospital Design Division



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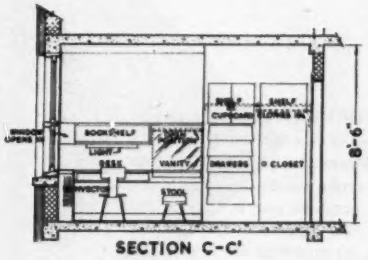

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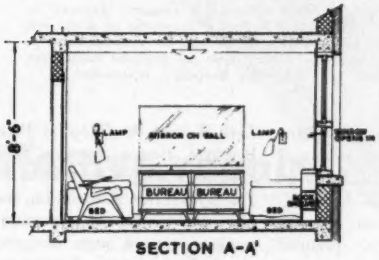

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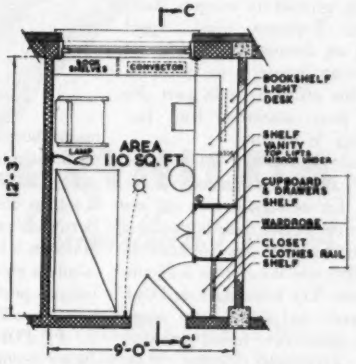
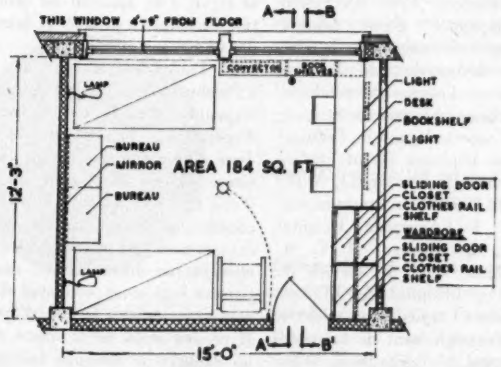


Single Nurse's Room



Double Nurses' Room

Minimum Requirements

SINGLE RM. 110 SQ. FT.
DOUBLE RM. 180 SQ. FT.

GRAPHIC SCALE

5 0 5 10

Les Hôpitaux Catholiques du Québec Se Réunissent

Au Congrès, S. Exc. l'Honorable Gaspard Fauteux (à gauche) a presenté à R.P. Ivan d'Orsonnens (à droit) une insigne portant la blason du Comité, en reconnaissance de ses longs états de service dans le domaine hospitalier. (Voir "The Canadian Hospital", septembre)

L'HISTORIQUE et pittoresque cité de Québec recevait, les 23, 24 et 25 juin dernier, les quelque 3,000 congressistes venus assister au congrès des hôpitaux, organisé par le Comité des Hôpitaux du Québec. Ce XVIIIe congrès a certainement été le plus important et le mieux réussi du genre.

Le thème général du congrès était: Davantage! Toujours plus! Appel pressant à un dévouement de plus en plus grand au devoir, à un effort de plus en plus efficace de la part des hôpitaux pour atteindre leur fin: mieux servir le patient.

La séance d'ouverture fut présidée par le R.P. Ivan d'Orsonnens, S.J., de Montréal. En reconnaissance de ses longs états de service dans le domaine hospitalier, le Comité des Hôpitaux du Québec offrit une décoration à l'éminent religieux. Les hommages de l'Université Laval, qui fêtent cette année même son centenaire, furent présentés par Mgr Ferdinand Vandry, P.D., recteur de cette vénérable institution. M. Emile Blain, M.D., président de l'Association des Médecins de Langue française du Canada et M. Murray Ross, secrétaire-adjoint du Canadian Hospital Council apportèrent les hommages de leurs groupes respectifs.

L'exposition commerciale et scientifique qui accompagnait ce congrès fut ouverte officiellement par S. Exc. l'honorable Gaspard Fauteux, Lieutenant-gouverneur de la province de Québec. Les 134 kiosques occupés par 112 exposants occupaient le vaste pavillon de l'agriculture, au terrain de l'exposition provinciale. M. Roland Levert, assistant du Président du Comité, était l'organisateur et le directeur de l'exposition.

Dans son allocution d'ouverture, le R. P. Hector-L. Bertrand, S.J. président du Comité, fit part à l'assistance des activités de l'année ainsi que des développements récents dans le domaine hospitalier national, soulignant particulièrement le travail accompli par le Canadian Hospital Council, dont il est un des vice-présidents. Le R. P. Bertrand présente aussi au Docteur Malcolm T. MacEachern, premier laïque à recevoir cette décoration, une insigne portant le blason du Comité, telle que celle qui avait été présentée au R. P. d'Orsonnens. Cette décoration était accompagnée d'une citation élogieuse, en reconnaissance de l'incomparable dévouement du Docteur MacEachern à l'oeuvre hospitalière, depuis de très nombreuses années.

Quelques aspects légaux de l'administration des hôpitaux furent étudiés par M. Charles-U. Létourneau, M.D., secrétaire du Conseil de Pratique professionnelle à l'American Hospital Association, de Chicago. M. C. A. Gauthier, M.D., chef du service de Neurologie à l'Hôpital de l'Enfant Jésus, Québec, traita du médecin praticien, l'enseignement de la médecine et l'hôpital. M. Emile Blain, M.D., exposa ce que le médecin attend de l'hôpital. Cette séance de l'après-midi fut présidée par M. l'abbé Victorin Germain, de Québec, ainsi que la discussion qui suivit les conférences.

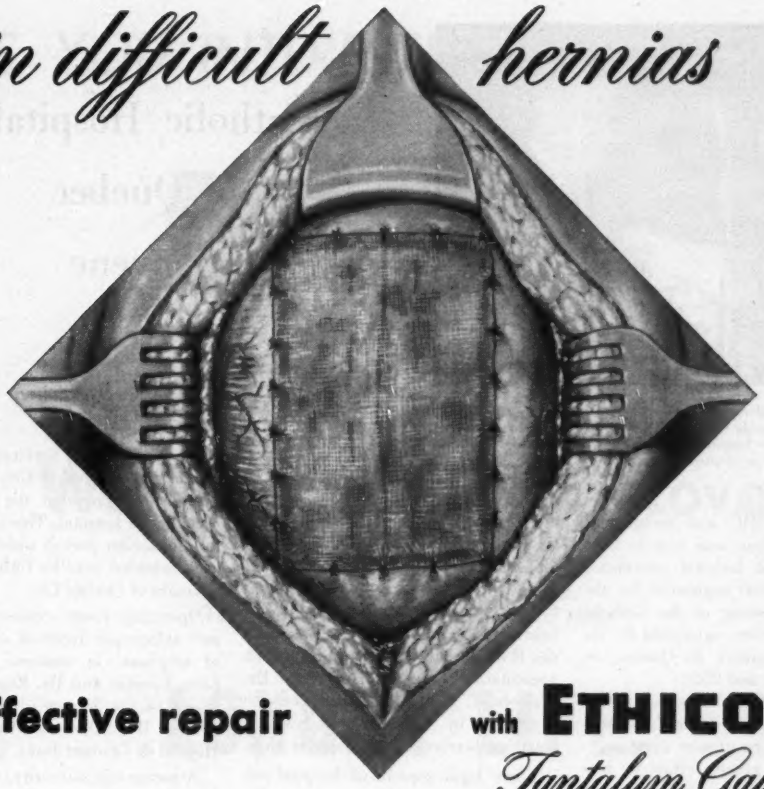
La séance du matin, 24 juin, était sous la présidence de M. Léon Longtin, M.D., chef du service d'Anesthésie à l'Hôtel-Dieu de Montréal. Le docteur Carl Walter, de l'Hôpital Peter Bent Brigham, Boston, membre du Comité des Salles d'Opération de la National Fire Prevention Association, une autorité universellement reconnue en la matière, exposa avec compétence et clarté les dangers d'explosion à la salle d'opération et les moyens de protection à employer. Le docteur Walter se servit d'un appareil de démonstration de nature à prouver et faire saisir davantage son sujet.

M. Paul Guest, Bureau des Mines, à Pittsburg, Penn., donna des exemples frappants d'explosion à la salle d'opération. En dépit du degré élevé d'humidité de l'atmosphère—environ 65 — M. Guest, au moyen d'une table d'opération miniature, de coussins, de draps, et caetera, venant en contact avec l'éther, l'oxygène et autres éléments de même nature, démontra, par des explosions, comment elles peuvent se produire à la salle d'opération. Il prouva aussi de la même manière les dangers de certaines habitudes de procéder, à cause de l'électricité statique des salles de chirurgie.

M. Harold Tétreault, M.D., directeur médical de l'Hôpital Saint-Luc, Montréal, décrivit d'une façon intéressante et pratique ce qu'est un service d'urgence bien organisé. Le R. P. Jules Paquin, S.J., exposa les principes

(Suite sur la page 72)

in difficult hernias



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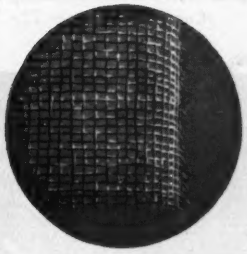

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The booklet "Tantalum Gauze . . . Its Use in the Repair of Large Hernias" will be mailed on request.

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Father Hector L. Bertrand presents Dr. Malcolm T. MacEachern with a badge and citation in recognition of his contribution to the hospital field. (For full citation, see the September issue.)

Catholic Hospitals of Quebec Convene

THE HISTORIC and picturesque city of Quebec was host to Canada's largest hospital convention as well over 3,000 registered for the 18th annual meeting of the Catholic hospitals of Quebec, organized by the Comité des Hôpitaux du Québec, on June 23rd, 24th and 25th.

The general theme of the convention was "Davantage!"—"More!", suggesting a call for even greater devotion to duty, and even greater effort by hospitals toward effective realization of their purpose.

The opening ceremonies were presided over by Rev. Father Ivan d'Orsonnens, S.J., of Montreal, who was honored by the Association for his long period of service to hospitals. Greetings were extended to the convention by his excellency Monseigneur Ferdinand Vandry, P.D., Rector of Laval University, Dr. Emile Blain, president of the Association of French Speaking Doctors of Canada, and by Murray Ross, Associate Secretary of the Canadian Hospital Council.

The commercial and scientific exhibition was officially opened by his excellency, the honorable Gaspard Fauteux, Lieutenant-Governor of the Province of Quebec. The 126 exhibit spaces, occupied by 100 exhibitors, extended over the whole main floor of the arena at the provincial exhibition grounds, where the meeting took place. Roland Levert, assistant to the president of the Comité, directed the exhibition.

In his presidential address, Rev. Father Hector L. Bertrand, S.J., outlined the year's activities and brought the delegates up to date on national hospital affairs, noting particularly the activities of the Canadian Hospital Council of which he is a vice-president. Father Bertrand presented a badge bearing the coat of arms of the Comité des Hôpitaux du Québec, the first such presentation to a lay person, to Dr. Malcolm T. MacEachern, together with a citation in recognition of his outstanding service to the hospital field.

Some legal aspects of hospital administration were discussed by Dr. Charles U. Létourneau, Secretary, Council on Professional Practice, American Hospital Association, Chicago. "The practicing physician, medical teaching, and the hospital" was the subject assigned to Dr. C. A. Gauthier, Chief, Neurological Service, Hôpital de l'Enfant Jésus, Quebec City. Dr. Emile Blain spoke on what the doctor expects of the hospital. This session, and the discussion period which followed, were presided over by l'Abbé Victorin Germain of Quebec City.

Operating room explosion hazards and safeguards received a good deal of emphasis in sessions under Dr. Léon Longtin and Dr. Eugene Allard, Chiefs of the Service of Anaesthesiology at Hôtel-Dieu de Montréal and Hôpital de l'Enfant Jésus, Quebec City.

A recognized authority, and a member of the National Fire Prevention Association's Committee on Operating Rooms, Dr. Carl Walter of the Peter Bent Brigham Hospital, Boston, gave a clear and informative address on explosion hazards in the operating room.

(Concluded on page 72)

All English addresses were translated into French by versatile Dr. Gerald La Salle, above.

First to be Held in Canada—

Institute on Hospital Pharmacy

THE long-anticipated Institute on Hospital Pharmacy, conducted by the American Hospital Association in co-operation with the American Society of Hospital Pharmacists and the American Pharmaceutical Association, was held on the University of Toronto campus, Toronto, Ont., during the week of June 23rd. This institute is an annual event in the United States and, on its first Canadian visit, was sponsored by the Canadian Society of Hospital Pharmacists and the Canadian Hospital Council.

The keen interest in the institute was well demonstrated by the representative group of hospital pharmacists who came from cities as far away as Victoria, B.C., St. John's, Nfld., Edmonton, Alta., and Los Angeles, California. There was such an overwhelming number of applications this year that many had to be turned away. The final registration figure was about 160, with about 65 per cent of the registrants, men and 35 per cent, women.

Every aspect of the hospital, as it relates to the pharmacy department, received thorough attention by the outstanding panel of speakers at the institute. A very commendable feature was the practical approach and effort to solve the various problems encountered by the hospital pharmacist, on the part of the faculty. Faculty members were, for the most part, pharmacists from the staffs of large and small hospitals, teaching and otherwise, ready to assist and advise after the presentation of each paper.

In his address on "Hospital Administration and Responsibilities of Pharmacy Service", R. Fraser Armstrong, Superintendent, Kingston General Hospital, Kingston, Ont., pointed out that, from the administrator's point of view, pharmacy ranks high among important departments, especially so, with the changing trends in pharmacy practice, the necessity of a pharmacy training program for student nurses, the pharmacy student, interns, and graduate nurses. The administration's responsibility to the patient to give medication which will return him to health at lowest possible cost consistent with good patient care is a challenge to the pharmacist. In the discussion which followed monthly, annual, and special reports to the administration were stressed as a means toward maintaining closer contact.

Dorothy M. Morgan, Director of Nursing, University of Chicago Clinics, Chicago, Ill., discussed the developments in nursing which require pharmacy adjustment. She emphasized that pharmacists must have an appreciation of the problems of other departments and, when planning changes in procedure, a statement of reasons would often be conducive to better co-operation. Emphasis was placed on the fact that pharmacy procedures should be handled in the pharmacy so that nurses are relieved of such responsibilities. It was pointed out that it was important to have a well-organized delivery service of supplies and prescriptions to the floors, and monthly inspection of nursing stations; and that all bottles of pharmaceutical supplies should be bottled in the pharmacy.

Waldo W. Buss, Associate Director, University Hospital, Ann Arbor, Michigan, and Stan W. Martin, Associate Executive Secretary-Treasurer, Ontario Hospital Association, Toronto, spoke on purchasing and accounting as applied to the pharmacy. From these authorities came the advice that all purchases for the pharmacy department should have the amount, specifications, and source, set by the pharmacist. Consideration should be given to the cost of processing an order as well as the charge to the patient, From discussion following, there appeared to be a great variation in methods of charging the patient and it was apparent that a cost accounting system would assist in setting up price schedules.

Charles W. Burr, President, Canadian Society of Hospital Pharmacists, Royal Jubilee Hospital, Victoria, B.C., dealt with the basic objective of pharmacy practice in hospital—patient care. This goal can be achieved by curing, prevention (receiving more emphasis now than formerly), education, and research.

Workshop sessions, using the Phillips 66 Technique, took up the entire Tuesday morning. They covered a variety of topics, each one in itself of utmost importance, with a report from each group presented at the evening session for further discussion.

During the rest of the week, a diversified list of subjects was presented and discussed. Some of these were: problems of design for new and established hospital pharmacies; time and motion studies; equipment and lay-outs for small-volume production; efficient utilization of personnel time; newer compounding aids; formulation of new manufactured products; professional and public relations; assay and control of manufactured products in a hospital

(Concluded on page 90)

Left to right, are: Gloria Niemeyer, assistant director, division of hospital pharmacy, American Pharmaceutical Association, Washington; Walter M. Frazier, chief pharmacist, Springfield City Hospital, Springfield, Ohio; A. J. Swanson, superintendent, Toronto Western Hospital; C. W. Burr, president, Canadian Society of Hospital Pharmacists, Royal Jubilee Hospital, Victoria, B.C.; Irene O. Olynyk, secretary of the Canadian society, Women's College Hospital, Toronto; A. A. Brown, secretary of the Canadian Foundation for the Advancement of Pharmacy, and Dr. C. U. Létourneau, secretary, council on professional practice, American Hospital Association, Chicago.

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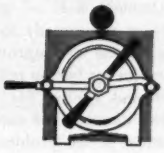

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British Columbia Presents

Health Survey Report

THE report of the British Columbia Health Survey Committee, another in the series of provincial health surveys, was tabled recently in the House of Commons by the Minister of National Health and Welfare, the Hon. Paul Martin. Highlights of the report were the recommendations that consideration be given to introducing a comprehensive health insurance plan to cover children only and that general health insurance for the entire population not be introduced.

The entire report contains more than 125 recommendations for improving health services in the Pacific coast province. Officials made it clear that the report reflects the opinions and proposals of officers of the provincial health department and that it does not bind the provincial government to action. They also indicated that about 80 of the recommendations have already been acted upon or are in process of being carried out.

The committee notes that complete health insurance is not now as urgent for British Columbia as it was a few years ago because of the province-wide hospital insurance program and the complete medical care program for recipients of social allowances. It places high priority on a health insurance program for children (excepting dental care) as a means of developing a healthy population for the future and of reducing the hardship which the cost of medical care for children brings to many families. It was suggested that the costs of such a program be split between the parents and governments.

To obtain more reliable laboratory diagnosis and to cut the costs of diagnostic radiology, the report recommends consideration of subsidizing these two services, using the centres recognized by the B.C.H.I.S. It also urges that "immediate consideration" be given to a plan whereby governmental purchases of drugs should be direct from the manufacturer.

As a further step toward health insurance, the committee suggests that the services of medical specialists might be made available without charge to the patient in such fields as arthritis, geriatrics, paediatrics, and dermatology, in the same way that services are now given for tuberculosis, cancer, and venereal disease. It also suggests "close study" of the pilot plan of complete health insurance for a single community as proposed by the Medical Services Association of British Columbia.

The report recommends a revision of the Health Act and suggests that, when this is completed, consideration be given to delegating to the health department full responsibility for the safety of milk and milk products.

In its survey of general provincial health services the report recommends: (1) an increase in the number of health educators in health units; (2) steps to improve relations with daily newspapers; (3) further study of health education and nutrition programs; (4) an acceleration of the preventive dentistry program; (5) a study of the relationship and responsibilities of the V.O.N. and public health nursing services; (6) a pilot project in which the public health nurse takes responsibility for a home nursing program; and (7) construction of a new health laboratory in Vancouver.

A number of these projects, including the hiring of additional health educators, an increase in dental services in health units and in the Greater Vancouver area, and the convalescent nursing service in Vernon, have already been implemented with the aid of federal health grants and provincial funds. It is anticipated that a federal grant will be used to supplement provincial funds in the construction of a new provincial health building in Vancouver.

Eleven recommendations are included relating to tuberculosis control, eight of which have already been put into effect. These include appointment of a full-time director of tuberculosis control; appointments of a medical records librarian, a personnel assistant, and qualified hospital administrators; construction of a new sanatorium in Vancouver; provision of equipment for general hospitals so that they can develop a program of routine chest x-rays for all admissions, as well as out-patients and re-organization of the mass x-ray program to confine it to those areas where miniature x-ray equipment is not accessible in general hospitals. Continuing study is being made of the mass x-ray program to see if it cannot be further developed to diagnose other ailments of the chest cavity.

Thirty recommendations relate to venereal disease control, including development of polyclinics and clinics open in the evenings; a study of the social, economic, educational, occupational, mental, and geographic factors which might be significant among the 20-24 age group with recent venereal infection; a more active health education program to acquaint teenagers with the facts concerning venereal infection; a more extensive program of bloodtesting for syphilis, and use of pencillin to control hidden syphilis. Approximately half of these recommendations are already in effect.

As a means of improving laboratory services for testing milk and water supplies and testing for tuberculosis and other diseases, the committee suggests study of the problem of setting up branch laboratories, the training of more personnel, and the purchase of a mobile laboratory. Proceedings are already underway on the first two recommendations.

Ten recommendations, five of which have already been carried out, are made in the section dealing with cancer control. Emphasis is placed on the necessity for more information to both the general public and the medical profession on the early and accurate diagnosis of cancer. The report recommends centralization of radiotherapy in a single centre, supported by consultative and diagnostic services in selected centres throughout the province.

The section on mental health underlines the importance of developing child guidance clinics and of outpatient services in general hospitals for the care of mental disorders in their early stages. Also recommended is construction in the Vancouver area of an observation and treatment centre for emotionally disturbed children. The committee notes the importance of the

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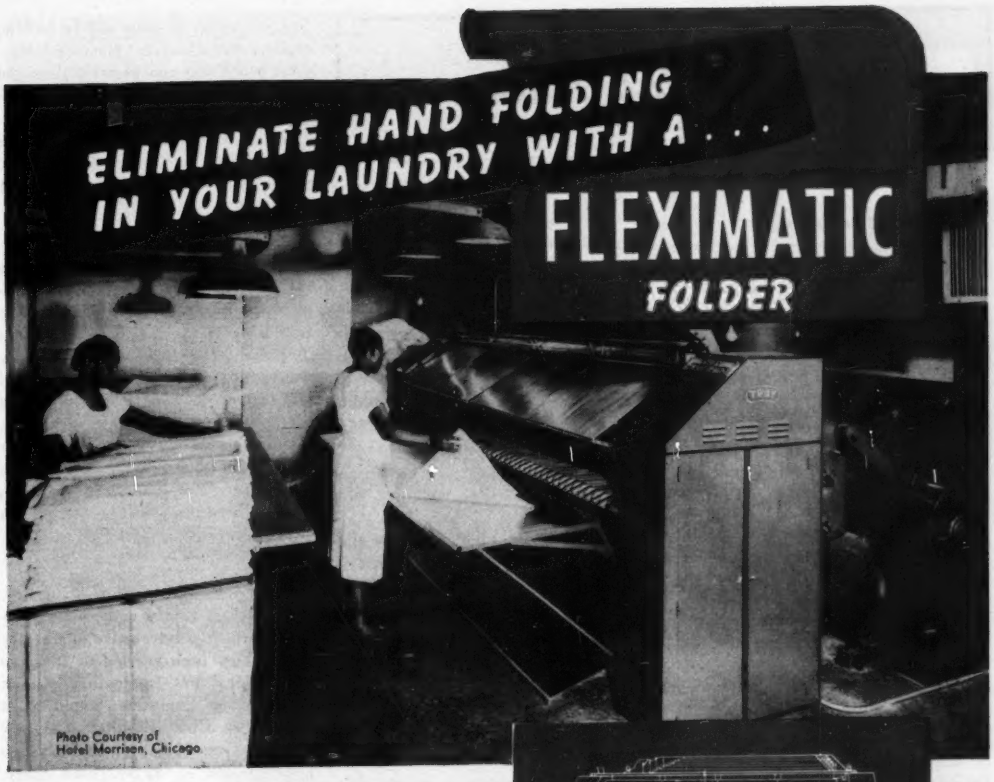

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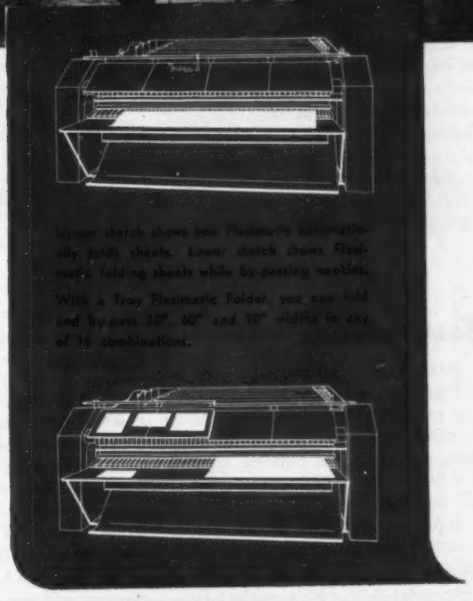

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Provincial Notes

British Columbia

VANCOUVER. Tenders have been called for the construction of a new wing to St. Vincent's Hospital, which will house more than 100 bassinets. A new administration office will be located in the new wing and considerable remodelling will be undertaken in the older section of the hospital.

Alberta

TURNER VALLEY. Assets of the Oilfields General Hospital have been officially turned over, by the hospital's board, to the Municipal Hospital District No. 66, which took over the operation of the hospital at the beginning of July.

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WHITELAW. The Hotel Dieu of St. Joseph was officially opened at the end of June. Located on a 60-acre farm on the edge of the town, the hospital will be a home for aged persons and those suffering from an incurable disease whether adult or child. A feature of the hospital is the large combination sunroom, library, and patients' lounge, which has a southern exposure and stretches the length of the building.

• • • •

Saskatchewan

BALCARRES. At an official ceremony in June, Premier T. C. Douglas opened the new $240,000 Balcarres Union Hospital. Built of re-inforced steel, concrete, and brick, the building is rated as a 30-bed unit. On the main floor of the building are: two public, three semi-private, and three private wards; a six-bed children's ward; an isolation ward; a 15-bassinet nursery; operating room suite; x-ray and laboratory facilities; business office; waiting room; and an out-patient examining room. The kitchen, laundry, heating plant, and storage rooms are located in the basement. Terrazzo has been used on all floors throughout the hospital and the ceilings are of acoustic tile.

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MELFORT. The new wing of the Melfort Union Hospital was officially opened at the beginning of July. Bringing the hospital's total bed capacity to approximately 75, the $250,000 addition was completed in about two years.

Manitoba

MORDEN. Some 1,500 residents and visitors gathered to watch the official ceremony which opened the new Morden District General Hospital at the beginning of July. A new nurses' residence was also opened. The older hospital will continue to serve the people of the district as a home for the aged and infirm.

• • • •

WINNIPEG. A recovery room, estimated to cost approximately $75,000, was completed recently at the Winnipeg General Hospital. Measuring 40′ by 14′, the room is painted a restful green and contains six beds, with space available for a seventh. Sliding curtains are used to screen off individual beds and beside each bed is a cupboard with sliding glass doors, which enables the nurse to see the contents at a glance.

Ontario

BRANTFORD. Plans for the erection of a 100-bed nursing home for chronic patients, to be operated in conjunction with the Brant County Home for the Aged and Infirm, have received the approval of the provincial government. Brant county will finance 20 beds and the remainder will be financed by the city of Brantford. The provincial government will pay half of the total cost of construction, equipment, and the net operating cost.

• • • •

HANOVER. It is expected that a 25-bed, one-storey hospital will be built to replace the Hanover Memorial Hospital which was considerably damaged in a recent fire. Plans call for the remodelling of the older building to accommodate chronically ill patients. The proposed new unit would be connected to the older section by a tunnel.

• • • •

OAKVILLE. The board of governors the Oakville-Trafalgar Memorial Hospital are proceeding with plans for the first wing in the hospital's expansion program. The proposed two-storey wing will accommodate 62 beds and will extend eastward from the end of the present surgical and medical unit. Comprehensive expansion plans call for a maximum of 315 to 325 beds, when all the proposed extensions are completed. These plans will be carried out as the need arises.

• • • •

OTTAWA. A 15-cent-an-hour wage increase, which is retroactive to January 1, 1952, has been granted to 23 members of local 869, International Union of Operating Engineers, employed at the Ottawa Civic Hospital. The new increase gives class two engineers an hourly wage of $1.38; class three, $1.29; class four, $1.10; and helpers, 97¢. The contract will be in effect until January 1, 1953.

• • • •

TILLSONBURG. Ontario's minister of health, the Hon. MacKinnon Phillips, formally opened the new three-storey wing at the Tillsonburg District Memorial Hospital. Built at an approximate cost of $775,000, the wing contains 100 beds and 27 bassinets.

Quebec

LACHINE. The Hon. Dr. J. A. Paquette, provincial minister of health, officially opened the new 48-bed Lachine General Hospital in June.

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MONTREAL. Ground will be broken this summer for a new wing at the Jewish General Hospital, which will increase the hospital's bed capacity from 226 to 366. New laboratory and re-

(Concluded on page 89)

With the Auxiliaries

B.C. Hospital Auxiliaries Convene on U.B.C. Campus

The British Columbia Association of Hospital Auxiliaries met in convention on the University of British Columbia campus from June 18-20, with 52 voting delegates registering. Eighty reports were read from auxiliaries scattered throughout the province. Membership in these auxiliaries ranges from 5 to 90 and, although problems are many and varied, all have one purpose in common—service to their hospital.

A five-member group, which serves the hospital at Pender Harbour, has raised $1,000 for the hospital despite ill winds and high tides. Meeting twice monthly, these auxiliary members are required to travel by water to attend their meetings. Another group, the Penticton Junior Auxiliary, has pledged itself to furnish a wing in the new hospital at a cost of $7,000 and much of this amount is already in the bank. Auxiliaries at Nanaimo and Kamloops are publishing cook books. The Kamloops ladies have already sold advertising space to cover the cost of publishing, assuring the group of a 100 per cent profit.

At Powell River, auxiliary members work in stores on busy days, donating their wages to the group. The Ocean Falls auxiliary makes washable felt slippers for long-term patients and another auxiliary gathers rags, which are sold to garages at 15 to 20¢ per pound. These are but a few of the many extensive projects and novel ideas which auxiliary members, throughout the province, undertake for their hospitals. The association has been promised a display table for next year's convention, thus affording delegates an opportunity to exhibit some of their excellent money-raising ideas.

Several significant resolutions were adopted by the convention and are as follows:

(1) That the membership fee be changed to a per capita fee of 10¢ per member, with a minimum of $1.00 and a maximum of $10.00.

(2) That registering delegates pay a fee of $1.00.

(3) That the provincial association select and purchase life membership pins for sale to the auxiliaries (thus standardizing the pin for life membership in the province).

(4) That the auxiliaries write to their member of parliament protesting the 5 per cent amusement tax levied on their entertainments.

(5) That the Association place a resolution to be presented at the Mayors Conference in Winnipeg in July protesting the ban on raffles for charitable endeavors.

(6) It was recommended that each auxiliary write their federal member protesting the ban on sweepstakes for charitable purposes.

The constitution of the British Columbia Association of Hospital Auxiliaries was amended to delete the offices of third and fourth vice-presidents and to include five to ten councillors to be appointed by the executive. Further constitutional changes will be brought in at the next annual meeting by a committee consisting of the president, the first and second vice-presidents, and the secretary.

The convention closed with a luncheon under the convenorship of Mrs. C. S. Stigings. The guest of honour was Mrs. T. S. G. McMurtry, of Vernon, winner of the $100 Judge and Mrs. J. M. George award for the best essay on how an auxiliary may help the hospital, who read her essay.

Some of the members of the British Columbia Association of Hospital Auxiliaries, who will take office in October, are pictured above.

Back row, standing left to right: Mrs. Forbes Perkins; Mrs. Ruby Sutherland; and Mrs. F. E. Atkinson.

Front row, seated left to right: Mrs. R. H. Mawhinney; Mrs. C. S. Stigings; Mrs. H. C. McPhalen; Mrs. A. Woodward; and Mrs. G. A. Bishop.

Officers

The new slate of officers, who will take office in October, are as follows:

President: Mrs. H. C. McPhalen, Westview (re-elected by acclamation)

First Vice-President: Mrs. Forbes Perkins, Vancouver

Second Vice-President: Mrs. F. E. Atkinson, Summer land

Secretary: Mrs. A. Woodward, Powell River

Treasurer: Mrs. J. Warriner, Vancouver

Publicity: Mrs. Ruby Sutherland, Vancouver

Councillors: Mrs. C. S. Stigings, Vancouver; Mrs. R. Mawhinney, Nanaimo; Mrs. W. G. Crawford, Victoria; Mrs. J. Stitt, Williams Lake; Mrs. M. Nickolson, Rossland; Mrs. G. A. Bishop, Oliver; Mrs. E. L. Deller, Ocean Falls; Mrs. C. R. McMillan, New Westminster; and Mrs. F. Milne, Alert Bay.

—Ruby Sutherland

("Auxiliaries" continued p. 60)

Maritime Hospital Aids Hold Annual Meeting

The annual meeting of the Maritime Aids Association was held at the Algonquin Hotel, St. Andrew's-by-the-sea, N.B., June 5th and 6th, in conjunction with the 10th Annual Convention of the Maritime Hospital Association.

Reports on association activities were received from Mrs. James Ross, Truro, N.S., retiring president; from the retiring secretary, Mrs. P. J. Connolly, Sidney, N.S., and from the treasurer, Mrs. H. A. MacQuarrie. Speakers heard by the delegates included Neil D. MacLean, Charlottetown, P.E.I., president, Maritime Hospital Association; E. J. Holland, Halifax, president, Maritime Hospital Exhibitors' Association; and Ralph H. Gale of the Saint John General Hospital.

The importance of the hospital auxiliary in public relations and in linking the hospital to the community as well as the financial assistance provided by these voluntary workers was emphasized by the speakers and borne out by the reports. In her presidential report, Mrs. Ross disclosed that more than $100,000 had been subscribed towards hospital work in 1951 by some thirty-three auxiliary groups in the Maritime provinces.

Mrs. B. L. Moran of Chatham, N.B., was installed as the new president of the association. Other officers elected were: first vice-president, Mrs. G. Leach, Charlottetown; second vice-president, Mrs. P. J. Connolly, Sydney; third vice-president, Mrs. A. M. Hunter, Halifax; fourth vice-president, Mrs. Eli Boyaner, Saint John; recording secretary, Mrs. Walter Carson, Moncton; corresponding secretary, Mrs. R. B. Stewart, Chatham; treasurer, Mrs. H. A. MacQuarrie, Westville, N.S.

Mrs. B. L. Moran

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Active Auxiliary at Saskatchewan Hospital, Weyburn

At a meeting of the auxiliary to the Saskatchewan Hospital, Weyburn, N. R. McDonald, Q.C., of Weyburn, a director of the Canadian Mental Health Association, attended to formally constitute the auxiliary as an affiliate of the C.M.H.A. Mr. McDonald outlined the work of the association as being chiefly to further education and research to preserve the mental health of the general public. At the meeting, leaders of various committees reported on activities undertaken by the auxiliary and on projects which were being planned. During the month of May, 49 pounds of reading material were distributed personally to the patients, as well as many small treats. Members hope to interest local citizens to work actively with the auxiliary or to donate current reading material and small comforts or treats.

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Annual Meeting Held by Auxiliary at St. Mary's Hospital, London, Ont.

At its annual meeting, ladies of the auxiliary to St. Mary's Hospital, London, Ont., approved a donation to the hospital of $370; bringing to approximately $600, the total amount given to the hospital during the past year. The money will be used to purchase a piece of equipment for the instittution. Convenors of the various committees read their reports and the president congratulated members on the excellent work accomplished during the year.

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$1,000 Donated to Hospital

Members of the ladies auxiliary to St. Joseph's Hospital, Saint John, N.B., recently presented their hospital with a cheque for $1,000. The money was raised at the annual Maytime Tea.

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Auxiliary Plans to Purchase Special Bath Equipment

A unanimous vote by members of the ladies auxiliary to St. Joseph's Hospital, Guelph, Ont., approved the purchase of a whirlpool bath to be installed in the hospital's physiotherapy department. The ladies recently conducted a successful tag day and, in June, held a reception for the graduating nurses.

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Notes on Federal Grants

Cancer

The St. Joan of Arc Hospital, Montreal, is organizing a clinic for the detection and treatment of cancer. It will be staffed by a radiologist, working part-time, a technician in radiology, a technician in pathology, a social worker, and a secretary. The social worker will be responsible for maintaining regular contact with outpatients. This is the only one of the larger hospitals serving the French-speaking population of Montreal which up to the present time has not had a cancer clinic. The federal grant of $9,500 will pay half of the salaries of the staff and assist toward the costs of hospital care for persons with cancer.

Construction

Two hospitals, a Red Cross nursing station, two health centres, and two nurses' residences in British Columbia have just been awarded federal health grants to help meet their building costs. Communities receiving the grants are: Salmon Arm, Pouce Coupé, Hudson Hope, Enderby, Kamloops, Vancouver, and New Westminster.

The largest single grant, more than $167,000, goes to the Vancouver General Hospital to assist with the cost of completing the eighth floor of its present nurses' residence and adding two new wings to the building, bringing its capacity to 407. At the Provincial Mental Hospital, New Westminster (recently re-named Woodlands School), a new unit is being added to the present nurses' residence. It will have accommodation for 99 nurses and a seven-bed infirmary. The federal grant will be $56,500, with the remainder of the cost being met by the province.

At Pouce Coupé, in the Peace River district east of the Rockies, a hospital has been under construction, since 1947, as money became available and with the assistance of labour donated by the community. About 75 per cent of the construction work is now completed and it is hoped that the building will be finished this year. It will have space for 24 beds. On the basis of the construction not yet completed when the federal government's health program came into effect in 1948, a federal grant of about $20,700 has been approved to assist with this work.

In the same area, a federal grant of $2,000 has been earmarked for a two-bed outpost nursing station at Hudson Hope. Construction of this station was completed by the British Columbia division of the Canadian Red Cross Society two years ago but a request for federal assistance was not received until recently. This station serves a small population scattered over a wide area around Hudson Hope. At Salmon Arm, the General Hospital is increasing its bed capacity by completing work on the ground floor of its east wing. This will provide space for seven additional beds, bringing the hospital's capacity to 38. It serves an area with a population of about 8,000. The federal grant of more than $4,400 meets one-third of the cost of the project.

A sub-office for the North Okanagan Health Unit is being built at Enderby. It will contain a clinical room and offices for the resident public health nurse and for the visiting medical officer, sanitary inspector, and dentist. Construction is being financed by federal and provincial grants of $2,600 each, with the remainder of the cost being met by a local service club which is donating labour and providing building supplies at reduced cost. A federal grant of $11,490 has been earmarked for the new health and welfare centre being built by the provincial government in Kamloops. It will contain clinical and examination rooms, a laboratory, a dental operating room, as well as office space for the health unit director, public health nurses, the sanitary inspector, dental officer and his assistant. Construction is scheduled for completion this fall.

In Ontario, the New Liskeard and District Hospital, New Liskeard, now more than half completed, will receive a grant of about $47,000. The hospital will have space for 40 patients and a 17-bassinet nursery, as well as medical, surgical, and obstetrical facilities. It will serve about 16,000 people in New Liskeard, Cobalt, Haileybury, and surrounding townships.

The new Northwestern General Hospital, near Toronto, will receive a federal grant of more than $114,600 to help toward the cost of providing accommodation for more than 100 patients, a 29-bassinet nursery, and medical, surgical, and obstetrical services. Construction is scheduled for completion next spring, with the costs being shared by federal and provincial governments, the county and township of York, and by public subscription. Also in Toronto, a new nurses' residence is being erected at the I.O.D.E. Hospital for Convalescent Children. It will provide accommodation for 31 nurses. The federal grant will be $15,500.

In Orangeville, Ontario, the Lord Dufferin Hospital is adding a new wing, renovating an old wing, and demolishing the oldest part of its present building to provide additional accommodation for 75 patients and for a 20-bassinet nursery. Construction, now more than half completed, is being financed by a federal grant of $81,600, by public subscriptions, and grants from the province, Dufferin county, the town of Orangeville, the township of Caledon, and other municipalities. This hospital serves about 14,000 people in Orangeville, Grand Valley, Shelburne, and surrounding townships.

One hospital in New Brunswick and two laboratories, connected with hospitals, have recently been awarded federal grants to help meet their construction costs. At the Victoria Public Hospital, Fredericton, a new wing is being added to provide space for 22 additional beds, and a new nursery. The federal grant toward this work will be $39,000. As a means of developing laboratories to serve both hospitals and public health personnel, the federal government undertook, during 1951, to assist with building costs for this type of project. A grant of $83,300 has been authorized for the provincial laboratory in Saint John and $28,500 for the regional laboratory in Moncton. Both laboratories will be operated by the provincial Department of Health and Social Service.

In Winnipeg, Man., the Concordia Hospital will be remodelled and enlarged to provide space for 45 additional beds and a 14-bassinet nursery.

(Continued on p. 64)

its casualty department, x-ray, and laboratory services will be available to out-patients. This hospital, operated by the Mennonite Hospital Society, serves about 30,000 people, mainly in East and North Kildonan, the town of Transcona and surrounding rural areas. The federal and provincial governments are each contributing more than $54,600 toward this project, which is scheduled for completion next year.

The Dauphin General Hospital, Dauphin, Man., will receive a federal grant of $8,500 toward its new nurses' home. The residence will provide accommodation for 19 nurses, when remodelling is completed later this year.

Mental Health

The federal government is renewing its grant to the Saskatchewan division of the Canadian Mental Health Association. Since it was set up about two years ago, this organization has done extensive work in promoting sound mental health, especially among children; in dispelling public ignorance about mental disorders; and informing the public about existing diagnostic and treatment services and the ways in which these can be used.

The association is working with teachers, nurses, doctors, clergymen, and the officers of local and provincial organizations to determine each one's part in the total mental health program. It has developed an active program of public education through newspapers, radio, movies, public speeches, study guides, and other informational material. Further, it is exploring the possibility of developing a family care program for certain mental illnesses and of obtaining volunteers to help with recreational and occupational therapy programs in the provincial mental hospitals. This organization also acts as a consultant to individuals and to a variety of agencies, including organizers of a co-operative nursery school, management, and labour groups. The work of the Saskatchewan division is supported by private donations and grants from the provincial and federal governments. The federal grant this year will be $6,000.

Professional Training

Three bursaries for special training in psychiatry and bacteriology have been awarded to residents of Quebec. A doctor from Levis is beginning a three-year course in neurology at the Montreal Neurological Institute and will, subsequently, be attached to the Hôpital de l'Enfant Jésus, Quebec City. Another doctor is taking two years' training at the Montreal Neurological Institute and, later, will be attached to St. Luke's Hospital, Montreal. The third bursary goes to a man from Montreal, who is taking a three-year post-graduate course in bacteriology at McGill University. On completion of the course, he will join the staff of the St. Jean de Dieu Hospital, Gamelin, P.Q.

Six bursaries for advanced training in such public health specialties as nursing, psychiatry, bacteriology, and tuberculosis control, have just been awarded to residents of Newfoundland, Prince Edward Island, and Nova Scotia. A member of the staff of the Grace Hospital, St. John's, Nfld., has been awarded a bursary which will enable her to spend a year at the University of Toronto studying general hospital and maternity nursing. Two bursaries have been allotted to residents of Prince Edward Island. A nurse from Charlottetown will spend a month in Saskatchewan, Alberta, and British Columbia studying their public health nursing programs, with particular emphasis placed on health education methods and arrangements for training staff. A doctor from St. Peter's, P.E.I., will begin a two-year post-graduate course in psychiatry at Dalhousie University, Halifax, this fall.

Three awards have been approved for Nova Scotia. One bursary has been allotted to a senior technician in the provincial laboratory, who has just completed a refresher course in enteric bacteriology at the federal Laboratory of Hygiene, Ottawa. Another bursary goes to a doctor from Halifax, who is taking a two-year course in x-ray diagnosis and therapy at Bellevue Hospital, New York, after which he will join the staff of the Victoria General Hospital, Halifax. The third bursary has been awarded to the superintendent of the Kentville sanatorium, who will spend three months in the United Kingdom where a special tour of British tuberculosis control work has been organized by the National Association for the Prevention of Tuberculosis.

Public Health

In Manitoba, a federal grant of more than $16,000 has been earmarked for the province to help in setting up an advisory field staff to assist local health units. Its purpose, as outlined in the Buck Report of 1950, will be to channel the plans and policies of the specialized divisions of the provincial health department to the 13 local health units in such a way as to bring about local programs balanced to meet local needs. The new field staff will consist, at the outset, of a doctor experienced in public health administration, a public health engineer with experience in all phases of environmental sanitation, and a nurse with extensive experience in general public health nursing. They will be available for this work on a full-time basis.

Tuberculosis

A federal grant of $16,000 has been allotted to the Jordan Memorial Sanatorium, The Glades, N.B., to help meet the building costs of the recently completed nurses' residence. Removal of the nursing staff to the new residence makes six additional beds available in the sanatorium for tuberculous patients. Remainder of the building cost is being met by the province, which operates the sanatorium.

The St. Lawrence Sanatorium, Hull, P.Q., has just been awarded a federal grant of $10,647 to buy technical equipment. The new apparatus will enable the medical staff to make more nearly complete diagnoses, especially prior to chest surgery, and to plan and carry out adequate treatment. There are about 120 patients in the sanatorium and consideration is being given to enlarging it.

A grant of $260,000 has been awarded to the new Sudbury-Algoma Sanatorium, now nearing completion at Sudbury, Ont. It will provide space for 155 tuberculosis patients from the city and district of Sudbury and the neighboring districts of Algoma, Nipissing, and Manitoulin. The nearest sanatoria at present are in Gravenhurst and Haileybury.

Opportunity

Thank God every morning when you get up that you have something to do which must be done, whether you like it or not. Being forced to work and forced to do your best, will breed in you temperance, self-control, diligence, strength of will, content, and a hundred other virtues which the idle never know.—*Charles Kingsley.*

◂ Health Care Plans ▸

Ontario Blue Cross Offers Surgical, Obstetrical, Medical Plan

At a recent meeting of the Board of Directors of the Ontario Hospital Association, approval was given to a surgical, obstetrical, and medical plan which will be offered as supplementary coverage to the present Blue Cross plan for hospital care. The new plan has been developed in response to numerous requests from Blue Cross groups who desire this type of protection in a "package" with their present hospitalization contract.

The surgical, obstetrical, medical "in-hospital" plan is being made available initially to employed groups and is obtainable only in conjunction with the Blue Cross hospitalization contract. The hospital care plan will still be available separately. At the present time, the new plan will be available on a group basis but if experience warrants it, can later be extended to cover individuals.

In enrolling for the supplementary plan, groups will have the convenience of dealing with one organization, one set of regulations, one contract, and one billing. The subscriber has unrestricted choice of doctor, and benefits will be available in any public general hospital anywhere.

The method of handling claims has been made simple for both subscriber and doctor and the Association is gearing to settle claims promptly. A subscriber may either submit his physician's or surgeon's account to the Plan for settlement or may have payment assigned directly to the doctor.

The new plan will be made available to groups on and after September 1st and will cost 95¢ per month for a single person and $2.95 per month for a family including husband, wife and all unmarried children under 18 years of age. Subscriptions are to be payable by payroll deduction through group at place of employment. If the employee should leave his place of employment or retire, he may keep his protection by transferring to another group or by paying directly to the plan on a quarterly basis at a slightly higher monthly rate.

* * * *

Eleven Nurses Win Awards in Blue Cross Story Contest

At the 26th Biennal Convention of the Canadian Nurses' Association, held in Quebec City from June 1st to June 6th, it was announced that eleven nurses had won awards in a story contest sponsored jointly by the Canadian Blue Cross Plans and the Canadian Nurses' Association.

Under the rules of the contest, which closed on April 30th, 1952, all registered nurses and senior nursing students were eligible. The contest consisted of writing stories which recounted actual, true-to-life experiences in connection with Blue Cross hospital service.

Two major prizes were awarded to Shirley Hepple, Windsor, Ont., and to Yvonne Levesque, Montreal, P.Q. Miss Hepple's story told of how Blue Cross helped a young couple meet the expenses of their first baby, and Nurse Levesque's story recounted the experiences of a family of nine who benefitted repeatedly from Blue Cross protection. In addition, there were nine other prizes for best entries from each province.

The judges for the contest were: Margaret E. Kerr, M.A., R.N., Editor and Business Manager, *The Canadian Nurse*, Gabrielle Charbonneau, Director of Public Health Nursing, University of Montreal, Reverend Father Hector L. Bertrand, S.J., President, Catholic Hospital Council of Canada, Dr. J. Gilbert Turner, Executive Director, Royal Victoria Hospital, Montreal, and J. R. H. Robertson, Chairman, Quebec Hospital Service Association, Montreal.

* * * *

Blue Cross Subscription Charges Increased in the Maritimes

Contract and rate adjustments, which became effective on August 1st, 1952, have been made by the Maritime Blue Cross—Blue Shield Plan. Blue Cross subscription charges were increased but Blue Shield subscription rates remain the same, although a few changes were made in this contract to bring it into agreement with the Blue Cross hospital contract. Increased use of Blue Cross services and higher rates of hospital payments made the contract changes and rate adjustments necessary.

Type of Contract	New Monthly Rates (payroll groups)	New Quarterly Rates (non-payroll groups)
Hospitalization (ward) for a single person	$ 1.20	$ 5.70
Hospitalization (semi-private), single person	1.40	7.05
Hospitalization (ward), family	3.20	13.50
Hospitalization (semi-private), family	3.60	15.00
Hospital-Surgical-Medical (ward), single person	2.32	9.30
Hospital-Surgical-Medical (semi-private), single	2.52	10.65
Hospital-Surgical-Medical (ward), family	6.20	23.10
Hospital-Surgical-Medical (semi-private), family	6.60	24.60

The Artists at Toronto Western Hospital

How many artists are there in your hospital? You will probably find that there are quite a few—if you search them out.

The Toronto Western Hospital made this pleasing discovery last March, with the opening of an attractive and interesting art exhibit. Hidden talent came to light in over 30 oil paintings, water colours, and charcoal sketches. These were displayed about the hospital's lovely new cafeteria which provided a well-lighted and graceful background.

Exhibits were submitted by a representative cross-section of the hospital, including members of the medical and nursing staffs, business office, kitchen, x-ray department, and other groups.

The exhibit lasted two weeks and was an overwhelming success, so much so, that it is planned to hold another and larger display next year—one which will include other artistic activities.

Le Bureau d'Admission

(Continué de la page 42)

patient à solder sa note.

Certaines lois concernant la vente des remèdes et des médicaments doivent être respectées. Il est permis aux pharmaciens de majorer le prix d'achat même de 40 pour cent pour les malades en chambre privée. Une taxe fédérale de 10 pour cent est alors ajoutée au prix de vente lorsque celui-ci a été majoré au-delà de 10 pour cent. Il revient à la pharmacie ou au bureau des comptes de noter régulièrement cette taxe et de conserver ces pièces justificatives afin de les présenter au besoin à l'auditeur comptable pour vérification. Un hôpital doit produire ses déclarations de taxe de vente et payer cette taxe tous les trois mois: le dernier de mars, de juin, de septembre et de décembre, au receveur local des douanes et de l'accise.

L'échelle des prix alloués aux remèdes et aux médicaments dans les hôpitaux est assez variable en ce qui concerne les cliniques. Dans ces circonstances, le pharmacien ou la pharmacienne doit s'en rapporter à son jugement et à sa charité.

Les Cliniques

La tendance de l'hôpital est de développer et d'agrandir les cliniques déjà existantes et d'en créer de nouvelles pour aider les individus et permettre aux médecins de prévenir, de diagnostiquer et de guérir la maladie. Ces cliniques externes sont appelées à jouer un grand rôle dans l'hôpital. Elles servent à développer son caractère scientifique et à favoriser son progrès à condition que tout y soit placé sous un contrôle unique. Quoi qu'il en soit, l'administrateur doit s'assurer que les cliniques soient organisées pour répondre en tous temps à l'urgence et que des heures régulières et précises soient assignées aux spécialités: dermatologie, nutrition, cardiologie, et caetera

Les cliniques ne sont pas et ne doivent pas être une source de revenus pour l'hôpital. D'après un usage général, on y demande la minime somme de vingt-cinq sous à l'admission des malades. Ceci comporte leur enregistrement et la carte identique qui doit être conservée et présentée a chaque visite à la clinique. On demande aux malades, et uniquement aux malades qui peuvent le donner, un montant de dix sous chaque fois qu'ils se présentent à la consultation. Le service des cliniques se fait toujours à perte comme le montre le rapport suivant d'un hôpital pour l'année 1948:

Nombre de consultations dans les différentes cliniques: 50,116; Le coût de chaque visite, 10 sous lorsque le patient peut le donner. Montant des gratuités pour l'année 1948: $80,836.-27.

Comme nous venons de le constater, les sources de revenus dans les cliniques ne sont pas nombreuses. Certains traitements tels que: insufflation tubaire, thermo-flo, electro-coagulation, ponction lombaire, chimisme gastrique, biopsie, et caetera sont pratiqués dans les cliniques. Les tarifs reconnus sont diminués de moitié et la plupart du temps, le malade fixe lui-même le montant qu'il peut donner pour le traitement, l'injection et le pansement. Les traitements d'electro-thérapie peuvent se donner à la clinique de psychiatrie pourvu qu'on dispose d'un local convenable pour assurer aux patients qui les reçoivent la tranquillité dont ils ont besoin dans ces circonstances. Le tarif de $2.00 en clinique est le montant alloué pour les electrochocs. Ce traitement d'une efficacité remarquable est d'un grand secours dans une clinique; il est même indispensable aujourd'hui avec le service de psychiatrie, surtout dans les temps que nous traversons. Les suites des deux guerres, la vie accélérée et étourdissante et bien d'autres facteurs, dans certains milieux de notre population, ont multiplié considérablement le nombre de psychoses et il devient urgent d'organiser des cliniques et de bâtir des hôpitaux pour ces malades (névrosés).

Nous avons essayé d'indiquer des moyens généraux pour obtenir l'uniformité des prix dans les hôpitaux d'une même localité et nous constatons que, dans l'ensemble, le résultat est encourageant. Dans certains hôpitaux des Etats-Unis et du Canada on utilise les méthodes suivantes dans le mode de paiement.

Ce que les Anglais appellent "flat rate" prix global, celui-ci est surtout utilisé dans un service de maternité. Comme la moyenne d'hospitalisation est de six jours et les services requis presque les mêmes: chambre et pension, laboratoire, anesthésie, soins au bébé, médicaments, pansements, il arrive que cette connaissance à l'avance du prix alloué pour cette spécialité est très appréciable.

"Regular rate" est d'après le taux régulier per diem. Dans cette catégorie, la durée de l'hospitalisation varie entre 2 ou 3 jours, aucune diminution du tarif n'est accordée. Cette méthode semble équitable et ne présente aucun inconvénient.

"Inclusive rate" est basé sur le séjour du patient, ordinairement une moyenne de 8 jours. Dans cette catégorie, on fait subir aux malades les mêmes analyses telles que electrocardiagramme, metabolisme, Van Slyke, bromsulfaléine, et caetera bien que leur maladie soit différente. Il est évident que si nous pratiquons une vérification générale "check up" pour tous les malades hospitalisés, les analyses nous révèleraient probablement des secrets. Mais le travail des laboratories serait par trop onéreux et les questions incessantes des malades: "Pourquoi tant d'analyses"? Cependant le médecin ou le chirurgien reste toujours le maître de son malade et à lui, par conséquent, revient le droit de demander l'analyse la plus apte à l'aider dans son diagnostic. Pourquoi lui enlever cette liberté de choisir le test qu'il désire? Il est fort douteux que le spécialiste d'expérience se jette d'emblée sur des systèmes tout préparés d'avance. Toutefois, ce mode de paiement est à la disposition des hôpitaux et il reste libre aux administrateurs de l'utiliser.

Les administrateurs doivent être prêts à fournir en tout temps, soit au gouvernement ou aux hôpitaux, une liste de prix concernant les différentes spécialités. Qu'ils soit précis et exacts dans leurs réponses. Le gouvernement veut savoir ce qui se passe dans les hôpitaux. Nous ne pouvons plus répondre: "Je ne sais pas ou je ne connais pas," mais il est de notre devoir de fournir des statistiques même élaborées et compliquées et de ne pas confondre et le nombre de traitements, de patients et de consultations. Ne craignons pas de dire ouvertement ce que nous faisons dans nos hôpitaux lorsque ces demandes nous viennent des autorités laïques ou religieuses, car la charité qui s'y exerce est magnifique et sublime et il n'est pas toujours recommandable de la dissimuler.

Pour compléter ce plan d'uniformité dans l'hôpital, ajoutons celui d'une tenue des livres et d'une presentation uniforme des comptes. A l'aide d'une machine spéciale, nous faisons les entrées au compte du patient, au compte de l'hôpital, au journal de

(Suite sur la page 80)

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For Gravity Collection:

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Abbott A-C-D Blood Container—A-C-D Solution, U.S.P. (N.I.H. Formula B), in the familiar conical-shaped Abbott intravenous bottles, 500- and 250-cc sizes. Blood is drawn (closed technique) directly into container by gravity. Also available with Donorpak 74 and 48, with or without disposable needles. Designed for exclusive use with Abbott I.V. equipment.

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VENOPAK®—Abbott's sterile, disposable venoclysis unit for the administration of all intravenous solutions. Converts readily to a blood recipient set with a special, disposable blood filter. For use exclusively with Abbott conical-shaped bottles.

(Series Hookup)

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SUB-Q-PAK®—A completely disposable preassembled hypodermoclysis unit with plastic T tube for administration of fluids subcutaneously.

ADMINISTERING PENTOTHAL® SODIUM

VENOTUBE®—Length of plastic tubing with attached male and female Luer adapters and pinch clamp. Allows anesthesiologist to keep syringe off the patient's arm. Pinch clamp offers additional factor of safety.

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Coming Conventions

Sept. 3-6—Annual Convention of the Canadian Society of Radiological Technicians, Palliser Hotel, Calgary.

Sept. 15-18—Annual Convention of the American Hospital Association, Philadelphia, Penn.

Oct. 7—Annual Convention of the Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 8-9—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon.

Oct. 16-18—Associated Hospitals of Alberta Convention, Palliser Hotel, Calgary.

Oct. 18-19—Ontario Society of Radiographers Convention, Chateau Laurier, Ottawa.

Oct. 22-24—Associated Hospitals of Manitoba Convention, Royal Alexandra Hotel, Winnipeg.

Oct. 26-29—Annual Convention of the Women's Hospital Auxiliaries Association, Province of Ontario, Royal York Hotel, Toronto.

Oct. 27-29—Ontario Hospital Association Convention, Royal York Hotel, Toronto.

Oct. 30-31—Annual Convention of the Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto.

Department Heads

(Concluded from page 40)

ishings and equipment which are not the responsibility of the department for cleaning or repair are still his responsibility in the matter of sending requisitions to the servicing departments. This responsibility includes a follow-up to ensure that requisitions are filled and, also, his final approval of the work.

"H" is for harmony. The department head should be in harmony with the ideals of the institution. Every hospital has rules and regulations. Larger hospitals usually have more written regulations than smaller hospitals. In either place, the department head must set an example to his staff, by complying with the rules of the hospital and must enforce them among his own departmental staff and, in most circumstances, also among other employees (for example, enforcement of "no smoking" in certain areas). The department head also maintains harmony by adhering to the organizational pattern of the hospital. For example, the department head should not take orders from some board member but should tactfully refer the member back to the administrator or, when some employee tries to take an inter-departmental matter over his head to the administrator or the board, the department head should insist that the chain of command be followed.

"T" is for training. The good department head, as has been suggested previously, is a teacher. In the small as well as the large hospital, new employees in the service departments come to the hospital with little or no knowledge of the hospital requirements of their job. On the clinical side of hospital work, nurses, laboratory and x-ray technicians, and auxiliary nursing staff come to the hospital with training and knowledge of their own work and usually a general knowledge of hospital organization. Both groups have something to learn. How are their own jobs to be done in this hospital? What is this hospital's organizational structure? How do they use it?

The department head is responsible for this orientation process. He is also responsible for instructing unskilled employees in the detail of their jobs. The unskilled employee requires much detailed instruction and supervision, the skilled worker requires less instruction and less supervision.

Instruction of employees may be carried out by formal classes, written instruction and bulletins or by informal talks, demonstrations, and conferences as the job is being done. A combination of formal and informal methods is best.

It is very important that the department head have a plan for increasing the usefulness and skill of his staff by covering the whole area of work thoroughly, and systematically. The department head must have persistence to carry this program through.

These then are the basic qualities and responsibilities of department heads: honesty, efficiency, interest, good housekeeping, harmony, training — "height".

In addition to basic responsibilities, a department head must know about the work to be done by each person under his charge. He need not be able to do each job well himself but must understand what is being done, why it is done that way, and must be able to judge if the job is being well or poorly done.

In every hospital the department head has certain duties to perform. An important one is the keeping of records. The Hospital Accounting Manual gives examples of the type of record required for almost every department. The elements of departmental records are these:

1. time worked by departmental staff;
2. materials used and their cost;
3. materials, products or work produced;

These headings apply equally well to the work of the nurse as to that of the maintenance man who fires the furnace.

Department heads in small hospitals have certain tasks to perform which are the same as those performed by their staff. The nurse in charge of a ward does nursing, dietary supervision, and charting. The housekeeper may clean some rooms, sew, keep stock, plan menus, or purchase. The administrator of the small hospital has nursing, purchasing, and accounting duties to carry out.

Thus every department head and sub-department head has responsibilities under these three headings: (1) accounting for the department; (2) supervision of others; (3) performance of his own specific duties.

The area of jurisdiction for each department head or sub-department head should be clearly defined. The senior department heads should know precisely for which departments they are responsible, and sub-department heads should know exactly for how much of the administrative detail of their sub-department they are responsible.

Think of the hospital "family". Measure the "height" of your department heads. Consider their ability to do their specific duties; be sure they are informed as to the exact area of their jurisdiction. Then, you will have a new appreciation of how you may improve your hospital.

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Catholic Hospitals of Quebec

(Concluded from page 50)

Dr. Walter made use of demonstration equipment and proved his versatility by using the podium, microphone, and anything else in reach as "props" to explain his subject point by point.

Dramatic proof of explosion dangers was given by means of a demonstration presented by Paul G. Guest of the U.S. Bureau of Mines, Pittsburg. In spite of a relative humidity of 65, the miniature operating room table, cushion, sheets, et cetera, combined with ether, oxygen, explosion chambers and other equipment, enabled Mr. Guest to show the peculiar habits, and dangers, of static electricity in the operating room.

Dr. Harold Tétrault, medical superintendent of St. Luke's Hospital, Montreal, described the operation of a well organized emergency service. Rev. Father Jules Paquin, S.J., spoke on professional secrecy.

As well as providing French translations of addresses presented in English, Dr. Gerald LaSalle, Assistant Director, Royal Victoria Hospital, Montreal, presided over the question period devoted to discussing the day's subjects.

The development and usefulness of a uniform system of hospital accounting and statistics, through the medium of the Canadian Hospital Accounting Manual, was described by Murray Ross of the Canadian Hospital Council. Dr. Jean Mercille, Medical Director, Hôpital Ste Jeanne d'Arc, Montreal, gave the administrator's view of the practitioner in the hospital. Patient relations were discussed by Wheeler Dupont, Director of Public Relations of the Laurentienne Insurance Company. Dr. Armond Rioux, a governor of the College of Physicians and Surgeons of Quebec and co-president of the Quebec Medical Association, presided over this session.

Solutions to problems arising from compensation cases were dealt with by a panel headed by Sister Gareau, r.h., director of the Claims Division, Hôtel-Dieu, Montreal, assisted by J. E. Demers, Medical Aid Officer of the Workmen's Compensation Board and his assistant, Noël Laroche.

Miss Jeanne Blanchard, Assistant Director of Social Service, Notre Dame Hospital, Montreal, spoke on the contribution of social service work in the hospital. "Professional Morals" was the final subject of the convention, delivered with oratorical vigour by His Excellency, Monseigneur Lionel Audet, Assistant Bishop of Quebec.

Following a final hour spent in visiting their friends, the exhibitors, the delegates returned to the mezzanine meeting hall for a final business session. With this a meeting of outstanding success was concluded.—M. W. R.

Les Hopitaux Catholiques

(Suite de la page 48)

de la morale sur le secret professionnel.

M. Gérald Lasalle, M.D., Directeur de l'Hôpital universitaire de l'Université de Montréal, donna une excellente traduction des travaux présentés en anglais, ceux du Docteur Walter et de M. Guest et présida les discussions sur ces sujets.

Les développements et la nécessité d'un système uniforme de comptabilité et de statistiques pour les hôpitaux, système auquel le Canadian Hospital Council travaille depuis des années, fut présenté par M. Murray Ross, secrétaire-adjoint de cette association. M. Jean Mercille, M.D., directeur médical, Hôpital Ste. Jeanne d'Arc, Montréal, parla du praticien à l'Hôpital, vu par l'administrateur. Les résolutions du patient furent présentées avec humour par M. Wheeler Dupont, C. R., directeur des Relations extérieures à la compagnie d'Assurance La Laurentienne. Cette séance était sous la présidence de M. Armand Rioux, M.D., gouverneur du Collège des Médecins du district de Québec.

Les problèmes qui s'élèvent souvent dans les cas d'accidents de travail furent étudiés avec maîtrise par Soeur Gareau, r.h., directrice du service des Réclamations à l'Hôtel-Dieu de Montréal assistée de MM. J.-E. Demers et Noël Laroche, officier et assistant-officier de l'Aide médicale à la Commission des Accidents du Travail.

Mlle. Jeanne Blanchard, assistante-directrice du Service social à l'Hôpital Notre-Dame, Montréal, présenta une intéressante conférence sur le service social à l'hôpital.

La conférence de clôture du congrès fut donnée avec une vigoureuse éloquence par S. Exc. Mgr Lionel Audet, évêque-auxiliaire de Québec, qui traita de la morale professionnelle.

Une heure de l'avant-midi et une de l'après-midi étaient consacrées à la visite de l'exposition. Le congrès se termina par des voeux et des résolutions à l'adresse de tous ceux qui avaient contribué à son succès d'une manière ou d'une autre—*Roland Levert*

Breakdown — A Film on Mental Illness

"Breakdown" is a National Film Board release, produced for the mental health authorities of Canada, in co-operation with the mental health division of the Department of National Health and Welfare. It can be obtained in 16 mm and 35 mm sizes, is in black and white with a sound track, and has a running time of 41 minutes.

The film tells the story of a young woman's schizophrenic breakdown and of her recovery in a modern mental hospital. "Breakdown" traces the case history of Anne Morton, a seemingly well-adjusted young woman in an average home environment and shows the disintegration of her personality to the point where she becomes separated from reality and causes grave concern to her family and friends. In hospital, we see Anne progress from a state of complete demoralization to a gradual return to normal volition and, finally, to a full reorientation of her personality. Other patients at various stages of recovery are also seen as well as a glimpse of a chronic ward.

"Breakdown" seeks to give the public a greater understanding of mental illness and to remove the stigma which surrounds the disease. The film has a very logical and comprehensive approach to the subject and moves slowly enough to permit the average person to assimilate the important aspects of the development of the disease as well as to see and understand the excellent treatment which is available in some of our mental hospitals today. It portrays attitudes in hospital staff as well as the various types of personnel in mental hospitals.

A committee is a gathering of more or less important people who singly can do nothing but who, collectively, decide that nothing can be done.
—*I.H.F. "News Bulletin"*

Role of the Administrator

(Continued from page 35)

tors. The corporate hospital acts by and through these human beings to perform its charter powers. The acts which they perform do not constitute the practice of medicine by the hospital in the sense in which that term is used with reference to the licensing of an individual doctor to practice medicine.

If the medical staff organization is adequate and if the administrator actively links the board with the medical staff to the end of co-ordinating their activities, and co-operates with the staff, he can exercise control without it being distasteful even to a group who are ordinarily rugged individualists.

If these tasks are performed honestly and in the interests of the patient primarily, the administrator reaches the point of maximum usefulness. Since the social point of view must prevail, business management is secondary, though important. The wise administrator knows how to assemble a group of expert heads of administrative departments to advise him in the same manner that he is advised by physicians in medical matters. The concept of the administrator's office as a clearing house for all hospital activity provides practical interrelationships, where the administrator is competent to act and is willing to be impartial in his dealings. Centralization of this kind in the modern hospital is essential and should be provided for in the scheme of organization, if for no other reason than to prevent confusion and duplication of effort.

The administrator will engage and control the resident and intern staff, if such is authorized. In this it is customary for him to confer with the delegated representatives of the medical staff in selection and in formulating general rules of conduct. As the administrative head of the hospital, he makes the individual contracts and assigns the members of the resident staff to duty in accordance with the rules laid down. They are instructed to take orders for treatment from the attending physician but, in addition, they may, with his consent, carry on treatment as they show themselves qualified. Otherwise, they are responsible to the adminstrator.

The sixth responsibility of the administrator is to survey the results of medical practice and care in his hospital.

Medical practice in hospitals today is vastly different from fifty years ago and our results are infinitely better today than yesterday. Could they not, however, be better now? A question that each administrator must ask himself is: "Is my hospital up to average?" During these days of increasing costs, much is written about the financial picture of hospitals. Could it be that some of us are too busy studying financial balance sheets to have any time left to study the human care balance sheets of our hospitals. On whose shoulders does leadership in this field rest—the trustees', the medical staff's or the administrator's? In many cases perhaps we, as administrators, have been too prone to walk a tight rope, trying to balance ourselves amid the pressures that come at us from many directions. Who else in the hospital is in a better position to see the over-all picture and to know what is required in the field of medical care than the administrator? If this is so, whose then is the greatest responsibility?

The administrator must be assured that the medical staff is securing results which conform to approved standards and are in accordance with the policies laid down by the governing board. The information which the administrator requires in this connection will be obtained in many ways: from the monthly medical staff meetings, from the chiefs of the various medical departments, from the statistical reports of the medical department, and from the medical audit where it is being carried out. The ideal, of course, would be a complete follow-up on every patient who passes through the hospital. Some hospitals have attained this with regard to public ward patients. Perhaps some day it may be applied generally to all patients.

Interpretation

The seventh responsibility is to interpret the results of medical practice. This can be done only by a study of figures published by other hospitals and by our national and international organizations, such as the American College of Surgeons. In the interpreting of these figures, the administrator must have the active assistance of the medical profession within the hospital. In small hospitals the chief-of-staff will

(Continued on page 76)

THE CANADIAN HOSPITAL

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Role of the Administrator

(Continued from page 74)

undertake the interpreting but in larger hospitals it will be the function of special staff committees.

Education

The eighth responsibility of the administrator is to educate. As the official link between the medical staff and the governing board, who are lay people with no particular medical background, the administrator has a continuing responsibility to educate the governing board with regard to medical practice within the hospital, and the trends and recent advances in medical practice. Frequently it will be his duty to explain to the governing board just why certain equipment becomes antiquated so quickly, why it is necessary to install equipment which was not necessary previously, and the need for opening new departments as medical practice advances. In most hospitals the administrator will undoubtedly find himself in the position of trying to satisfy, on one hand, the legimate demands of the medical staff for more and better equipment and, on the other hand, present these demands to a governing body who never have sufficient funds to do everything they would like to do for their institution. The administrator also has to educate the medical staff as to the over-all problems confronting the governing board and no opportunity to do so should be lost.

Encouragement

The ninth responsibility is to encourage the efforts of all concerned with medical care within the institution. The quality of the practice of medicine carried on in a hospital is eminently dependent not only on the method of staff organization, essential equipment and supplies, but also on the environment and atmosphere which exists. In many instances, much more can be accomplished by the power of suggestion than by direct orders given in an emphatic manner. If one thinks that the chief of surgery has done a good job of staff organization, why not tell him so, better still, why not see that his work is recognized by the board? Too often, too little is said about the long hours that the medical staff put in the hospital doing free work on the public ward service. Indeed, there is widespread feeling among the general public that the medical staff are paid for this work, just by whom I have never been able to determine.

Harmony

The final responsibility of the administrator, with regard to medical practice, is to promote harmony within the hospital. Within our institution we have many diversified groups; all are important but all must function smoothly, in harmony, to obtain the maximum results and benefits for our patients. This harmony does not just grow of its own accord—it has to be planted and cultivated. While it is a multiple-lane highway, the administrator must take the lead in travelling it. Not all hospitals have harmony to the same degree yet it has been proved over and over again that men of good will, with diversified outlooks, can join together and work in harmony in a common cause. What greater cause is there than having a share in the work of ministering to the sick, as the opportunity presents itself to us in our day-to-day work in hospitals.

Our understanding of today's broad

(Concluded on page 89)

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Protect Your Hospital

(Concluded from page 31)

Others who can contribute a great deal to the fire safety program are the housekeeping and maintenance employees. Good housekeeping and proper maintenance of equipment of all kinds are very important factors in fire safety. The elimination of combustible materials from every part of the building, particularly from basements, attics and inaccessible storage places, will greatly reduce the fire hazards in any building.

Fire inspection with written reports to the chief administrative officer who, in turn, will pass them to the trustees must be a rigid requirement of hospital routine. Regular and thorough inspections should be carried out at least weekly in hazardous areas and not less than monthly in all other areas. Such inspections should be the responsibility of a senior administrative person trained to recognize fire hazards. Extinguishers are quite often accidentally damaged or expelled and sometimes not reported due to fear of reprimand. Fire hoses become snarled and may be knotted in such a manner that they become useless when required. Fire doors occasionally get off the track or become stiff through need of lubrication. There have been occasions when someone has carelessly dropped bits of rubbish in the path of the fire doors in such a way that it blocked the door from closing. Doors leading to fire escapes become stuck and require attention. Outside fire escapes become dangerous due to erosion or to accumulation of ice and snow. Fire hydrants can become quite unserviceable through lack of use and regular inspection, and testing is imperative, especially, in the cold months.

Regular inspections should also be carried out by the local fire department and by the Insurance Underwriters' Association. In each case, a written report will be forthcoming for prompt corrective action by the hospital.

Such are some of the very important aspects of fire hazards and fire prevention. If we concentrate on fire prevention, our chances of needing fire protection are lessened considerably. We must train all members of our staff, both experienced and new, we must practise good housekeeping, we must inspect thoroughly and regularly, taking whatever action is indicated. By so doing we are ensuring the best methods of fire prevention possible.

The Place of Nutrition in the Health Education Program

Nutrition education is not just propaganda for better food habits, it has a world vision. Knowledge of nutrition, used for man's welfare through improvement of family and community food habits, could ultimately affect world conditions. There is a mass of facts about nutritive values and recommended allowances but such knowledge remains useless until educators do something about it. Teaching nutrition is an art. The artist suggests and lets the audience do the rest. A wise teacher will make use of education to open the way for children to discover for themselves that false standards, personal foibles, and mismanagement of money are frequently the causes of poor nutrition in this country.—*"American Journal of Public Health", March, 1952.*

Le Bureau d'Admission

(Continué de la page 68)

revenu avec la distribution adéquate pour chacun des revenus, le tout en une seule opération et avec un contrôle positif et absolu sur toutes les entrées. En outre, tous ces documents sont des originaux, aucun papier carbone n'est nécessaire. Un journal en détail est imprimé automatiquement vous fournissant un compte rendu des différentes transactions de la journée. Tous les renseignements nécessaires y sont inclus pour vérifications ultérieures. Comme sécurité absolue, aucune transaction ne peut s'accomplir par la machine sans qu'une impression des détails de cette transaction n'apparaisse sur ce journal.

Cette machine semble très recommandable pour la tenue et le contrôle des comptes du patient. Elle garantit une distribution exacte du revenu et assure que les montants portés aux comptes sont vérifiés sur toutes les pièces justificatives par la machine, au moment même de l'entrée. Enfin cette machine fournit un relevé quotidien des comptes des patients. Par son usage, on diminue les frais d'administration et ce qui est plus important on crée une atmosphère de sécurité et de bien-être.

Durant quelques années, on nous a prêché la standardisation absolue. Mais on s'est vite rendu compte du danger qu'occasionne un tel principe. Comment développe et encourager les initiatives si tout est standardisé? Loin de moi la pensée d'insinuer dans nos hôpitaux l'esprit d'individualisme mais ce que je souhaite, c'est cette caractéristique qui différencie un hôpital d'un autre. Un conseil très souvent répété par le révérend Père Schwittalla était celui-ci: "Avez toujours à la mémoire cette idée fondamentale que l'esprit qui doit vous animer soit celui de votre communauté, celui de vos fondateurs, celui de l'ordre où vous êtes." Et ailleurs, en parlant du nursing, il disait: "Le but de notre nursing est non seulement d'inculquer à nos infirmières un esprit catholique, mais de leur donner une direction particulière à leur école. "N'essayez pas", disait-il, "de transférer les règles d'une école du Canada aux Etats-Unis et vice-versa, car nous savons par avance quelles en seraient les conséquences."

Le soin du malade, objectif essentiel de tout hôpital, comporte un champ vaste et variable dans son exécution. Ce chercheur de santé physique et morale qui s'enregistre tous les jours dans nos hôpitaux, mérite bien en retour non seulement le confort qu'il a droit d'attendre, mais cette cordialité aimable et gracieuse qui met un peu plus de soleil dans sa vie. Donnons à notre hôpital l'esprit qui doit l'animer en conformité avec toutes les données scientifiques et modernes.

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4. Do not allow it to come in close contact with sources of heat.
5. Do not boil plastic parts unless the manufacturer's instructions specifically say that it is safe to do so.
6. Use a mild soap and water solution to clean transparent plastic.

—*"Bulletin", Dominion Oxygen Company Limited, July, 1952.*

WHO and its Accomplishments

In September, 1947, cholera struck Egypt. The outbreak spread with such rapidity that the entire Middle East was in danger. Vast quantities of vaccine and other supplies were urgently needed but were unavailable in that area. Immediately WHO—actually, at that time, the Interim Commission—alerted its forces, arranged for a world-wide speed-up in the production of vaccine, scoured the globe for existing supplies, and enlisted the services of many governments. From the four corners of the earth came medical supplies, 32 tons of them, mostly by air. Through the co-operative efforts of WHO and some 20 nations, working along with Egyptian authorities, the fight was won ten weeks after the original outbreak. In this dramatic fashion, the worth of an international health organization in initiating and co-ordinating activities was brought forcibly to the attention of the world.

Less dramatic, perhaps, but just as valuable are the projects WHO is carrying on, year after year, in all quarters of the globe through its advisory services, available on request to governments. Tremendous strides have been made in the mass control of disease. WHO has been particularly successful in reducing the ravages of insect-borne diseases like malaria, which kills about 3 million people each year. Insecticide campaigns against this disease have shown startling results. A campaign in Ceylon reduced that country's death rate, not only from malaria but from all causes, from 22 per 1,000 to 14.3.

The success of such campaigns has led many governments to tranform projects directed against specific diseases into general health programs for the welfare of all their citizens. Helping governments to plan national health programs is a major task of WHO. Assistance takes many forms, from supplying planning experts and travelling seminars to setting up health demonstration areas, as has been done in Ceylon, Egypt, and El Salvador, and sending out health demonstration teams. The latter work along with local health personnel who can then carry on efficiently after WHO withdraws. As an example, during 1951, WHO malaria-control projects gave protection to 1½ million people, a sizeable number. But WHO methods, carried on by others, protected an additional 50 million people.

Of course there is something more important than the treatment or eradiction of disease and that is its prevention. In this field, environmental sanitation is of the utmost importance and WHO has assisted many countries in planning efficient sanitary measures adapted to their own conditions.

One of the most serious handicaps in pursuing the struggle against disease and raising health standards, internationally and nationally, is the lack of trained personnel. For that reason, WHO has given top priority to training programs for all types of health workers. Last year, for instance, 665 fellowships were granted to men and women from 73 countries. Health education, too, is vital, for if health measures are to be of lasting value they must be accepted and understood by the people they serve.

Something has already been said of the technical services which WHO provides from headquarters. Among the international standards and regulations which it has drafted are the International Sanitary Regulations, which provide maximum security against the spread of disease; standards for biological products; regulations on health statistics, and the first international pharmacopoeia.

In all these efforts, whether it be a fight against typhus in Afghanistan or the training of health workers in South America, Canada in the long run benefits as surely as if WHO were conducting a campaign against some disease within our own borders. For no one today can escape the ill-effects of needless suffering and death anywhere in the world.—*From "Canada's Health and Welfare", April-May*, 1952.

Ontario and Federal Government to Share Immigrants' Hospital Costs

At the Canadian conference of social work, held in Quebec City in June, it was announced that an agreement had been reached between the Ontario provincial government and the federal government to share the hospitalization costs of immigrants on a 50-50 basis during their first year in this country. The federal government is negotiating with the other provinces to bring about similar agreements.

Behind the Scenes...

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This is only one of many large institutions using Radiant Heating with Page-Hersey Steel Pipe—chosen for dependability, economy and long life.

PAGE-HERSEY TUBES, LIMITED

Largest manufacturers of steel pipe in Canada

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WANT ADVERTISEMENTS

DIETITIANS WANTED

Two Dietitians are required for the 320-bed St. John's General Hospital. Applications should be addressed to the Medical Superintendent, St. John's General Hospital, St. John's Newfoundland.

DIETITIAN REQUIRED

Opportunity for fully qualified and experienced dietitian with executive ability to take charge of dietetic services for 190-bed general hospital operating training school for nurses. Excellent remuneration, accommodation available in nurses' home. Apply to Administrator, Royal Inland Hospital, Kamloops, B.C.

REPRESENTATIVE WANTED

WANTED—Representative calling on hospitals to sell high quality products used in large volume. Full or part time. Excellent additional line for established salesman. Please write, Darco Products Limited, Guelph, Ontario.

ASSISTANT ADMINISTRATOR

For Welland County General Hospital, Welland, Ont. Salary commensurate with qualifications. Apply by letter only giving full particulars of education, business experience, and qualifications which suit you for the position. Applications treated in confidence. References required. H. Barnett, Chairman, Board of Trustees.

MEDICAL RECORDS LIBRARIAN

APPLICATIONS FROM QUALIFIED MEDICAL RECORDS LIBRARIANS are being sought for the post of Chief Medical Records Librarian in 240 bed General Hospital. Further details upon writing: The Superintendent, St. Joseph's General Hospital, Port Arthur, Ontario.

CHIEF DIETITIAN WANTED

Chief Dietitian required. Board, lodging and laundry supplied. Must be capable of taking full responsibility for this department. Apply to Sister M. Joan, Assistant Superintendent, Sudbury General Hospital, Sudbury, Ont.

ADMINISTRATOR AVAILABLE

Widely experienced administrator of large hospital is leaving present position for family and personal reasons. Will be available at first of year. Medium to small hospital in Western Ontario peninsula, or Maritime Provinces, preferred. Salary secondary to location. Apply box 816G. The Canadian Hospital, 57 Bloor St. West, Toronto.

LABORATORY TECHNICIANS — BACTERIOLOGIST

190 bed general hospital requires two registered laboratory technicians and one bacteriologist or technician with bacteriological training. Opportunity to gain diversified experience in well-equipped laboratory under supervision of pathologist. Apply to Administrator, Royal Inland Hospital, Kamloops, B.C.

DIETITIAN WANTED IMMEDIATELY

Dietitian for 150 bed hospital—graduate staff—modern department—central tray service. Salary commensurate with experience. Apply—Superintendent, St. Joseph's Hospital, Sarnia, Ontario.

WANTED—REGISTERED MEDICAL RECORD LIBRARIAN

Royal Edward Laurentian Hospital, 3674 St. Urbain St., Montreal, requires Medical Record Librarian to take full charge of record room. Apply to: Medical Director, Royal Edward Laurentian Hospital, Montreal 18.

MATRON WANTED

For new fully modern 36 bed hospital. Attractive surroundings and ideal working conditions. Separate Nurses' Residence. Accumulative sick leave. one month holiday after 1 year of service. Duties to commence immediately. Apply stating salary expected, qualifications and experience. Mrs. M. Hamilton, Sec.-Treas. Neepawa district Memorial Hospital, Neepawa, Manitoba.

Panel Heating System

(Concluded from page 39)

panels rest on solid ground.

The supply and return mains for each quarter are 2½" standard pipe size. The supply pipe is carried down from the heat changer plant in the attic space, thence around the perimeter of the building, with all joints and coil connections, gas welded. Both ¾" and 1" pipe were used in coil fabrication. The return connections of the coils are made to the return mains placed under the main hall of the building. All the panel heating piping was subjected to a hydrostatic test before covering in, the requirement being 150 pounds per square inch for a period of six hours.

The most prevalent question concerning panel heating is its relative cost in regard to original installation, maintenance, and operation. As contractors become more familiar with the system, and are able to provide more efficient layouts, costs have been steadily reduced and compare favourably with other conventional designs.

Maintenance, however, still remains largely a matter of conjecture or opinion. In no other construction have similar problems been faced where differing co-efficients of expansion occur in a solid mass, over such a wide temperature range (50 to 120 degrees F.). Only once has the system at St. John's required repair—when a ¼" air vent pipe broke away where welded to the main supply pipe. Close checking revealed that concrete setters had cracked the joint during construction. Maintenance is the only "unknown" in panel heating to-day.

Operating cost—*i.e.*, fuel alone—shows a remarkable saving over the heating cost for the main building, against which must be balanced the difference in insulation, storm sash, air leaks through shrinkage, et cetera. Savings on a straight comparison basis are usually considered between 7 and 10 per cent in favour of panel heating in standard installations.

It is noteworthy that the Mount Sinai Hospital, now under construction in Toronto, is almost completely heated by radiant ceiling panels. While there are thousands of successful installations, this system is not applicable to every heating job, and it is strongly recommended that those considering its use should seek advice from architects and engineers experienced in its application.

B.C. Health Survey

(Concluded from page 54)

teaching profession in mental hygiene programs and urges the training of more teachers to act as links between the schools and the community's specialized mental health agencies. Of the 17 recommendations involving the provincial mental hospitals and allied services, action has already been taken on all of them.

In line with the recommendations on the care of crippled children, federal grants have already been used to carry out a survey of diseases among children and to set up a crippled children's registry as a step toward a positive program against certain children's diseases.

In its study of local health services, the survey committee suggests that (1) offices of local health services should be constructed wherever possible, in conjunction with the local hospital; (2) that training of more sanitary inspectors should be encouraged and (3) that further study be given to the value of school medical examinations.

What is being done about Arthritis?

(The following information is condensed from an article, by Mary J. Angus, M.S., of the Canadian Arthritis and Rheumatism Society, which appeared in the April-May, 1952 issue of "Canada's Health and Welfare".)

Four years ago, the Canadian Arthritis and Rheumatism Society was established. Despite the fact that the underlying cause of all serious forms of rheumatic diseases remains unknown, the Society faced squarely the broad problems presented by this affliction in Canada and summarized them in this manner. There was a marked shortage of special facilities for treatment of these diseases—particularly with respect to hospital care and social and vocational rehabilitation. There was a shortage of physicians with special training and experience in the diagnosis and treatment of rheumatism. About 100,000 Canadians are totally or partially disabled by these diseases, of whom about 15,000 are regularly confined to bed or wheelchair. About 80 per cent of the victims of the most serious kind of arthritis—rheumatoid arthritis—are between the ages of 25 and 50 at the time of onset. At the same time, the Society realized that much of the disability and deformity of rheumatism as seen today is quite needless. It is a fact that, given early diagnosis and treatment, 70 to 80 per cent of the victims of rheumatoid arthritis could either recover completely or be greatly improved. One obvious goal is to make this early diagnosis and treatment available.

The Society's program was developed with the recognition of these problems. It is divided between national and provincial projects. The two main national projects are research and professional education. At the present time, the Society is supporting research investigations in ten leading university departments and in the past three years, seven research fellowships and 21 research grants-in-aid have been awarded.

In order to increase the number of phsycians with special training and experience in the diagnosis and treatment of these diseases, three years ago, the Society adopted a program of professional education. Since that time 25 clinical fellowships have been awarded, enabling well-qualified phsycians to take further training in leading arthritis centres in Great Britain, the United States, and Canada.

In addition to providing the financial support for these national projects, the eight provincial divisions maintain their separate programs related to the diagnosis, treatment, social welfare, and rehabilitation of sufferers in their own area. In the past four years, the Divisions have assisted general hospitals to establish 25 arthritis clinics as adjunct services in their out-patient departments. These clinics not only provide increased and improved facilities for the care of low-income patients but serve also as a focal point for professional interest and clinical research.

The operation of 28 mobile units is another achievement of the provincial divisions. These units, consisting of a physiotherapist with portable physiotherapy equipment, bring required treatment under direction of the patient's own doctor, right to the home-bound patient. Patients are taught a routine of exercises so that, finally the therapist visists only in a supervisory capacity. With the current shortage of hospital beds and the expense of hospitalization, this form of mobile service is economically sound.

Both the Ontario and British Columbia divisions have rehabilitation projects in operation at the present time. The entire program is based on effective teamwork between the patient, doctor, physiotherapist, medical social worker, and rehabilitation counsellor.

One of the main objects of the Society is to make early diagnosis and treatment available. In many cases the disease starts insidiously and there is a tremendous job ahead for the Society to encourage people to seek early medical care.

Television?

An elderly Yorkshire couple, visiting an exhibition of domestic appliances in London, paused to gaze through the glass panel of a demonstration washing machine at a bunch of laundry that was being swirled.

"Well," said the lady of the pair, "if that's television they can have it."
—*English Digest.*

Provincial Notes

(Concluded from page 56)

search facilities as well as a new outpatient department will be included in the new wing, which is expected to be completed late in 1953. The new building will be located west of the present central wing and the recently completed nurses' residence.

New Brunswick

SAINT JOHN. The formal opening of the new nurses' residence at the Saint John Tuberculosis Hospital took place in June. The 57-bed building, was constructed at a cost of $187,498 and was equipped at a cost of $35,000. The former residence has been almost completely demolished to make way for a new surgical wing for the hospital which will contain 35 beds. A small part of the residence, which was not torn down, has been moved and will be utilized for some other purpose at a later date.

Newfoundland

CHANNEL. The new Channel-Port aux Basques Cottage Hospital was officially opened recently by the Hon. James R. Chalker, provincial minister of health. The hospital contains 24 ward beds, three private rooms, four children's cots, and six bassinets.

Role of the Administrator

(Concluded from page 76)

concepts of medical care and our comprehension of the expanding fields of health will reflect themselves in the services our hospitals provide in meeting the demands for better care of our patients. Our service will be as inclusive as our vision and as limited as our thinking and knowledge, because none of us will be content with less than the best care for our patients. We see stretching before us ever-widening horizons, knowledge rapidly unfolding, and more well-trained professional personnel available. The challenge is great; yet it is this vision which is our compensation.

To recapitulate, the administrator's responsibilities with regard to medical practice in hospitals are to organize, link, co-ordinate, co-operate, control, survey, interpret, educate, encourage, and harmonize the various groups within the hospital concerned with medical care.

In the Malayan Jungle

(An excerpt from an article which appeared in "Hospital and Health Management", London, Eng., March 1952.)

During and after World War II, some 400 re-settlement camps were established in the Far East. In these camps, the largest of which comprises nearly 2,000 houses, Chinese refugees have been lodged. British Red Cross welfare officers face the arduous and difficult task of operating mobile clinics to serve these people. Two Red Cross girls staff each clinic and make regular visits once or twice a week to the camps in their area. These visits are awaited eagerly by the inhabitants and large queues of patients form to receive treatment and medicine.

In these camps water and roads are provided by the government and there is comparative safety from the fear of bandit attacks. For this reason, other nationalities besides the Chinese have been attracted to the settlements. Among these are the Sakai, Malay aborigines, who are somewhat similar to gypsies They have most attractive children who, unfortunately, often suffer from skin diseases and the Red Cross workers offer their services to them.

Health and hygiene talks are a very important and popular part of the work carried out. Special emphasis is laid on child care and a large doll with sleeping eyes, used as a model, always arouses great interest. Much tact is necessary to convince the people that their methods of treating ailments are not as thorough as they could be.

In the more remote parts of the country where there are no roads, one Red Cross girl works single-handed. Travelling by jeep or sampan, she covers a large area of scattered villages, on a monthly program. Accompanied only by a native driver and interpreter, the Red Cross worker sets up a hut in each village as a dispensary.

In the more sophisticated areas such as Kuala Lumpur, there is much support from local members and the work centres around the hospitals. But whether driving unarmed through the jungle or taking care of crippled children in Singapore, these Red Cross workers are bringing their message of health and hygiene with equal determination and devotion to the remotest parts of the Far East. •

Pharmacy Institute

(Concluded from page 52)

pharmacy; newer ointment bases; nature and clinical use of resins and salt substitutes; clinical use of parenteral fluids; investigational drugs; current status of endocrine drugs, chemistry and incompatibilities of some of the newer drugs; selection and placement of stills and storage tanks; assay and sterility tests of large-volume parenteral fluids; and formulae, techniques, and special precautions for parenteral preparations.

Faculty

The faculty was composed of an impressive array of speakers, every one well qualified to speak in his field. Among these were: Arthur J. Swanson, superintendent, Toronto Western Hospital; Don E. Francke, chief pharmacist, University of Michigan Hospital; Dr. George F. Archambault, senior pharmacist, U.S. Public Health Service; Dr. G. C. Walker, associate professor of pharmacy, University of Toronto; Frank Zahalan, chief pharmacist, Montreal General Hospital; Herbert L. Flack, director of pharmacy service, Jefferson Medical College Hospital, Philadelphia, Penn.; Dr. Arthur W. Purdum, chief pharmacist, The Johns Hopkins Hospital, Baltimore, Md.; Assistant Dean F. Norman Hughes, Ontario College of Pharmacy, Toronto; Sister Mary Florentine, chief pharmacist, Mount Carmel Hospital, Columbus, Ohio; Dr. Austin Smith, editor, *Journal of the American Medical Association*, Chicago, Ill.; Dr. D. C. Darrow, Yale University School of Medicine, New Haven, Conn.; Dr. R. F. Farquharson, University of Toronto; and Dr. H. J. Shields, Toronto. Leonard Goudy of the American Hospital Association acted as co-ordinator of the institute.

Social Events

During the week, there were two social events. The first evening, the Canadian Society of Hospital Pharmacists played host to registrants by sponsoring "Canada Night". It was a very effective way of getting all the "Instituters" acquainted with one another and helped to rouse greater enthusiasm and participation during discussions. The evening was very informal and featured square dancing. A male quartet sang French Canadian folk songs, and Newfoundland sea chanties, while Scottish dancers entertained with reels, a sword dance, et cetera. The evening was brought to a close with a ceremony honouring the 10th anniversary of the American Society of Hospital Pharmacists. A large birthday cake was "piped in" and a presentation of ten Canadian silver dollars was made to Gloria Niemeyer, Assistant Director, Hospital Pharmacy Division, American Pharmaceutical Association.

The Canadian Society of Hospital Pharmacists was represented on the program by Mary E. Asquith, Stratford General Hospital, Stratford, Ont., F. D. Buck, chief pharmacist, Kingston General Hospital, Irene O. Olynyk, chief pharmacist, Women's College Hospital, Toronto, as well as by President C. W. Burr. The Canadian Hospital Council was represented by Dr. L. O. Bradley.

All in all, the week of June 23rd was a momentous one for the hospital pharmacists of Canada. They realized an objective that has been foremost since the inception of the Canadian society in 1948—an institute in hospital pharmacy. This institute was one of the most successful ever held and it is hoped that this fact will act as an incentive to hold more of these study periods in Canada whether in co-operation with our neighbours to the south or as a Canadian venture.

—Irene O. Olynyk

Accounting Institutes to be Held in Toronto and Ottawa

The Ontario Hospital Association is sponsoring two accounting institutes to study *The Canadian Hospital Accounting Manual.* These will be held in Toronto, at the King Edward Hotel, on September 10, 11, and 12th, and, in Ottawa, at the Chateau Laurier, on September 25, 26, and 27th. The institutes, which are being planned as workshops, will deal solely with CHAM.

All hospital personnel directly connected with accounting and statistical work are invited to attend the institute being held in the city which is most convenient for them. Further information is available from the Ontario Hospital Association, 135 St. Clair Ave., W., Toronto 5, Ont.

Heart Clinic Helps Cardiacs Discover Work Potentialities

A new approach to the ever-growing problem of whether cardiac cases can be gainfully employed and what positions they can hold is being made by the Work Classification Clinic of the Cleveland Area Heart Society, Cleveland, Ohio.

The clinic, working closely with employers in the Cleveland area, makes an intensive study of each cardiac case referred to it. On the basis of this study it is determined what work capabilities the patient has. This answers a problem often raised in cardiac cases for, if the worker decides he wishes to return to work, the employer is still faced with deciding whether he feels it wise to employ a cardiac. If a worker with this condition is rehired and aggravates his heart condition, the courts are likely to hold the company for maximum claims. On the other hand, if the worker is skilled, the employer does not wish to lose the benefit of the man's ability, talent, and the investment made in him.

An article in the January 19, 1952, issue of *Business Week* explains how the Work Classification Clinic operates. Most of the cases are referred to the clinic by the family or industrial physician, who also accepts the decision of the clinic as to the patient's future. To date the clinic has sent 205 workers (80 per cent of all clinic patients) back to jobs and not one of them has had to receive industrial compensation.

Each patient at the clinic has his medical history taken, receives fluoroscopic chest examinations, electrocardiograms, and exercise-tolerance tests. A thorough personal interview—covering the patient's worries, fears, responsibilities, et cetera—is also carried out.

The final step of the clinic's procedure is the interview with the vocational counselor. He reviews the requirements of the patient's former job. Either the counselor recommends that the patient return to his former job, that he be trained for and placed in a less exacting job, or that he not return to work.

Following the examinations and interviews is a discussion by all clinic staff members concerned with the case. Their final report is sent to the referring physician and then the individual employer makes his decision.

Herman K. Hellerstein, M.D., is the cardiologist in charge of the clinic which was begun in 1949 on a $5,000 grant from Republic Steel. Since that time the Cleveland Area Heart Society has paid the expenses. In 1951, the cost was about $5,000 and the budget for this year is $6,140. All of the clinic's services are free.—*From "X-ray News" April, 1951.*

MEDICAL RECORDS LIBRARIAN WANTED

For 200 bed general hospital with program of expansion.

DUTIES: To assist in establishing, and to later supervise the indexing and coding of diagnosis and systems of medical accounting.

SALARY: will depend on qualifications and experience.

Please address enquiries to H. F. Garwood, Administrator, Greater Niagara General Hospital, Niagara Falls, Ontario.

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Hundreds of "McKEMCO" users are obtaining better washing quality in less time than ever before. Scientifically formulated to suit local water conditions, this well buffered alkali with the high pH removes dirt with a minimum of time and effort and with little loss of tensile strength to the fabric—and saves soap too!

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New Norfield Posting Tray

A different type of tray that offers maximum security while allowing the contents to be handled easier is the new Norfield Posting Tray. It is extremely adaptable, taking cards of different widths by using the adjustable guide. The guide folds down to permit offsetting.

Because the tray is light in weight it is easily portable. It holds 1,000 cards in easy reach. Space at bottom saves nipping. Wide angle keeps sheets open for perfect visibility.

Over three years have been spent developing and perfecting this tray. It has been tested and proven superior in actual use according to the manufacturer. The purchase price is saved in a relatively short time by labor saved. For a complete descriptive folder, showing stand and posting box write Department 30, Physician's Record Co., 161 W. Harrison, Chicago 5, Illinois.

* * *

Westeel Catalogue of Office Partitions

Westeel Partitions provide an economical and efficient means of dividing large areas of space into sections of suitable size and shape, easily changed later on if occasion arises.

They are permanent partitions inasmuch as they will last for the life of the building. They are temporary partitions inasmuch as all or part of them can be moved as often as required without damage. Westeel partitions are of sectional construction, all steel, insulated and finished in durable baked-on enamel.

The outstanding advantages of these partitions are mobility and flexibility, plus excellent appearance. Three different types of Westeel partitions are attractively illustrated and described in detail in their new catalogue. Their nearest office will send you a copy on request.

* * *

Schapiro Pediatric Proctological Table

The Shampaine Company of St. Louis, Mo., is now introducing a proctological table for pediatric practice. This new Schapiro Pediatric Proctological Table was designed by Saul Schapiro, M.D., of the Department of Surgery, Jewish Hospital of Brooklyn, N.Y.

The first of its kind, it simplifies pediatric proctological examination and treatment. The child is placed comfortably in a fixed position for the best possible viewing and ease of instrumentation. The table lifts the abdomen forward and off the table to remove all pressure on the abdominal wall and causing the intestines and pelvic viscera to fall forward, thus facilitating the introduction of the examination instrument.

It is a very lightweight unit and can be placed on any flat table or surface. Its frame is of sturdy welded tubing finished in baked Silverlux enamel. Sponge rubber cushions are affixed to the frame and covered with durable acid-resistant plastic material.

Full information on the new Schapiro Pediatric Proctological Table may be obtained through any Shampaine Company dealer or by writing direct to the Shampaine Company, 1920 S. Jefferson Ave., St. Louis, Mo.

* * *

New Instrument Measures Conductivity of Floors

A push-button operated instrument, designated as Vibrotest model 267, has been developed to measure electrical resistance of conductive flooring in accordance with National Fire Protection Association Bulletin 56.

Used to test conductive floors where static charges, or stray electrical potentials, may cause explosions in hazardous atmospheres or materials. Original development work was for testing conductivity of floors in hospital operating rooms. Checks can be made to determine changes in floor conductivity caused by wear, washing, waxing or presence of foreign materials such as grease, iron filings and

(Concluded on page 96)

Across the Desk

(Concluded from page 94)

dirt. It can also be used for electrical insulation resistance measurements as well as wiring continuity and voltage checks.

Vibrotest model 267 has ranges of 0-20 megohms at 125 V.D.C. test potential and 0-200 megohms at 500 V.D.C. test potential. Also ranges of 0-20,000 ohms and 150-300-600 Volts A.C. and D.C. Instrument is housed in a welded steel case 12¼" x 9" x 10" and includes two special five pound measuring electrodes with pairs of five and ten-foot test leads. Weight complete with batteries thirty-one pounds.

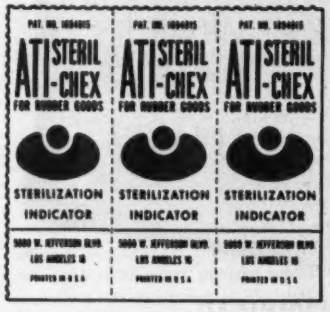
Further information upon request to manufacturer: Associated Research, Incorporated, 3758 West Belmont Avenue, Chicago 18, Illinois.

* * *

Improved ATI Steril-Chex for Rubber Goods

The Aseptic-Thermo Indicator Company, Los Angeles, California, announces the new, improved ATI Steril-Chex Indicator for rubber goods.

Greatly improved with sharper and more accurate colour change, these new indicators are easier to read and afford greater assurance that conditions



of sterilization for rubber goods have been met and maintained.

Each book of 250 Steril-Chex Indicators contains authoritative information relating to pre-sterilization procedure for rubber goods and instructions on how to use and how to read ATI Steril-Chex.

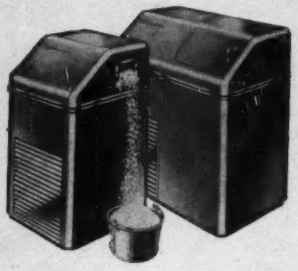
Aseptic-Thermo Indicator Company also produce the all-purpose "four-spot" ATI Steam-Clox Indicator and ATI Regulars for surgical packs.

Inquiries regarding literature, samples and further information can be directed to the company at 5000 West Jefferson Blvd., Los Angeles 16, Calif.

* * *

New Low Cost Automatic Ice Making Machines

Two new automatic ice machines—one for ice cubes, the other for ice flakes—lower in cost and simpler in mechanism are now being made available in Canada. Marketed under the trade name "Scotsman" and distrib-



uted by Quality Utilities Limited, 65 Villiers Street, Toronto, they offer new compact facilities for hospitals.

The Scotsman Super Ice Cuber is only 35" high—makes up to 2700 cubes (roughly 150 pounds of ice) a day. Scotsman "cubes" are, however, solid and round in shape.

The Scotsman Super Ice Flaker comes in two sizes, both sizes available with or without storage bin. For food storage and service and other purposes in larger hospitals and institutions, the model SF-2 produces 750 to 900 lbs. of flaked ice a day. The smaller "Scotsman" making 350 to 430 lbs. of ice flakes a day is ideal for smaller hospitals. The continuous flow type (without storage bin) produces ice continually until unit is shut off with manual switch and the storage type unit stops and starts automatically by thermostat at predetermined bin level.

Both operate with only one moving part under refrigeration thus eliminating complicated mechanism likely to get "out of order".

* * *

Gudebrod Offers New Suture Folder

An attractive new folder on their entire line of non-absorbable sutures is being offered to hospital personnel by Gudebrod Bros. Silk Company, Inc., New York.

Chief among the products featured is Champion serum proof silk sutures, highly regarded for high quality requirements. A copy of the new folder will be sent on request to all hospital personnel interested.

Fisher & Burpe's New Vancouver Premises

About the first of the year Fisher & Burpe's new Vancouver office was opened. The Company had previously occupied premises at 883 Howe Street, and the new building at 835 West Broadway is far from the congested centre of the city and near the hospitals. The office provides double the effective floor space available to service the Company's customers in the fast-growing province of British Columbia, and a convenient parking space for at least twenty cars is provided. The sales room and offices for the executive and sales staff are on the top floor which is at street level. This part of the building also contains the Lederle offices.

On June 18th the Company's President, Mr. R. W. Finlayson, the Sales Manager, Mr. W. C. Johnson, and the head of the new office, Mr. H. C. Day, received at a formal opening and party on behalf of the Western Canada Institute for Hospital Administrators and Trustees. Over one hundred and fifty guests attended and inspected the premises.

Index of Advertisers

AUGUST, 1952

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published monthly by The Canadian Hospital Council, 57 Bloor Street West, Toronto 5.

CORBETT-COWLEY MEDICAL GARMENTS give you

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Made from finest available materials

Designed for extra long wear

All Corbett-Cowley Operating Room Apparel and Equipment whether in colour or otherwise—is made from only the finest materials available. Each pattern is cut full with plenty of room for extra wear. All garments are expertly designed and skilfully produced to stand up under the most rigorous use.

Garments produced with scrupulous care, with special emphasis on workmanship and material . . . pay off in the long run. That's why Corbett-Cowley Medical Garments represent a sound investment for the buyer. All orders and enquiries given prompt attention. *Note: Sales Tax Added to Billings unless orders accompanied by Regulation Sales Tax Exemption Certificate.*

• HOUSE DOCTOR'S COAT

Style 103. Made of bleached drill, this coat is neat and serviceable. It has notched lapel collar, three pockets, detachable buttons and hemmed sleeves.

• SURGEON'S OPERATING SUIT

Style 356. This one-piece garment (no buttons required) is in great demand for surgeon's work. The adjustable tie tape belt and one piece features alone commend its use. Made from best quality bleached suiting. Stocked in even sizes 34-44. These garments also available in any colours—made to order.

• SURGEON'S BONE GOWN ➡

Similar to our style 431 with the addition of a flap which covers tie openings at the back and is held by all-round belt. This feature makes gown more sterile. Can be made in coloured, bleached or unbleached materials.

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AUGUST, 1952